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# A Catalogue of State Medicaid Program Changes 1982-1983

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The State Medicaid  
Information Center

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National Governors' Association

REPORTS

RA  
412  
.4  
C38  
1982/83



National Governors' Association  
Center for Policy Research  
Health Policy Studies

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## ACKNOWLEDGEMENTS

The publications, research, and other services provided by the National Governors' Association's State Medicaid Information Center Project are made possible by a grant to NGA's Center for Policy Research from the Office of Research and Demonstrations, Health Care Financing Administration, DHHS (HCFA Grant #18-P-97923/3-04).

The development and production of this publication was supervised by Lawrence Bartlett of Bartlett Associates, Washington, D.C. who is the Project Coordinator of the State Medicaid Information Center. Claudia Hanson and John Luehrs labored diligently to collect the bulk of the information presented here, while Larry Dzieza and Dottie Menard provided invaluable assistance in developing the computer software for preparing the Catalogue and inputting the data, respectively. Thanks are due to Richard Curtis and Joan Wills of NGA and Aileen Pagan-Berlucchi, HCFA Project Officer, for their support of the project. We would also like to express our appreciation to the Intergovernmental Health Policy Project of the George Washington University for the information it shared with us on state legislative activity.

Most importantly, however, thanks are due the state Medicaid directors and their staff for the valuable information on their individual states' activities which they shared with us. We are hopeful that the program data on all states compiled in this document will be of use to them in administering their programs and will prove adequate compensation for their efforts.

State Medicaid Information Center  
Health Policy Studies  
Center for Policy Research  
National Governors' Association  
444 North Capitol Street, N.W.  
Washington, D.C. 20001  
(202) 624-5300

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## INTRODUCTION

States have been faced with the challenge of developing policies which would control the growth in their Medicaid program expenditures while striving to minimize any adverse impacts of such policies on the provision of health care to those in need. In order to make the best possible choices among various policy alternatives, it is important that state officials have at their disposal complete and up-to-date information on potential cost containment approaches.

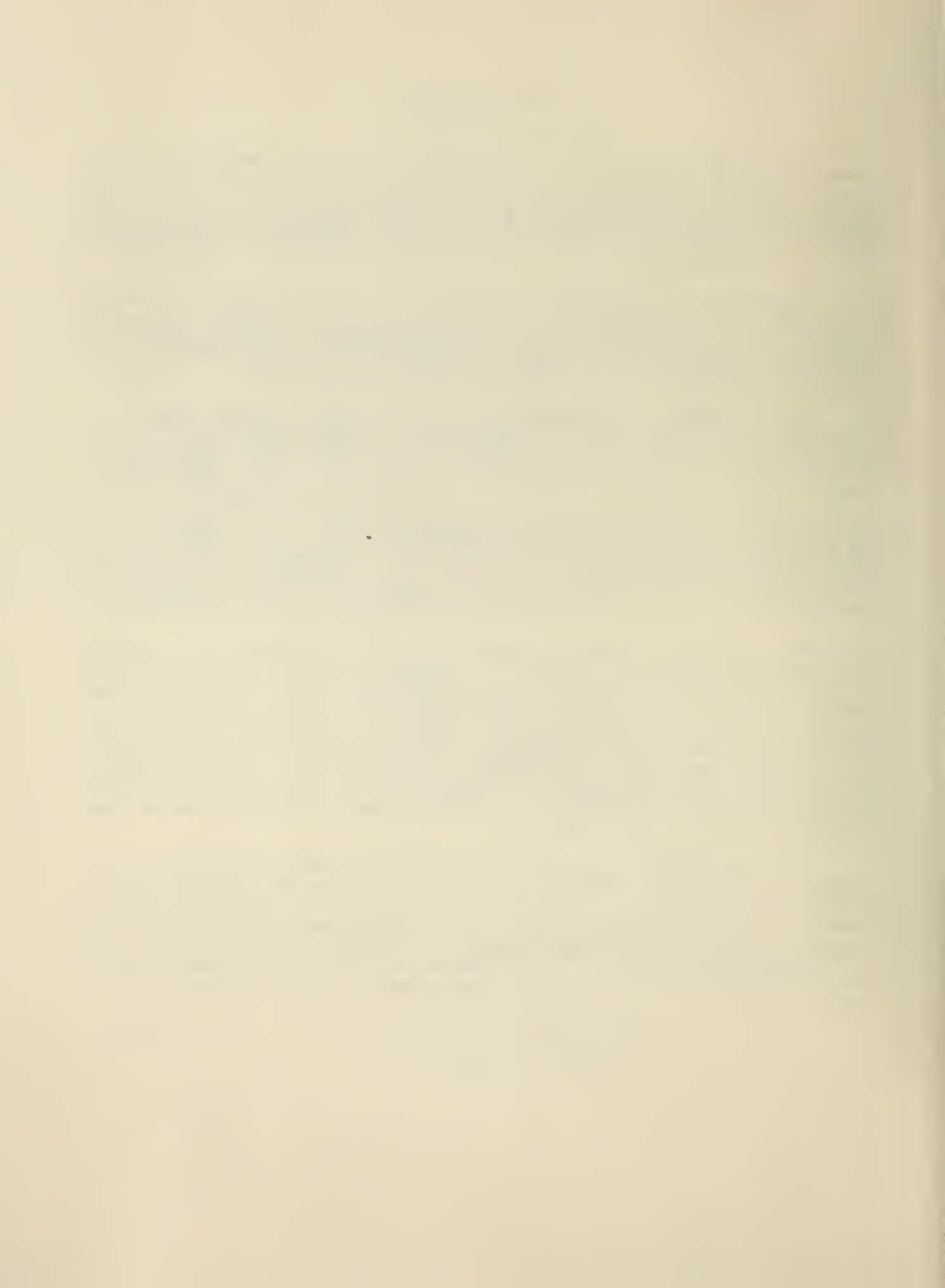
To address this critical information need, the National Governors' Association's Center for Policy Research, through a grant awarded by the Health Care Financing Administration, has established the State Medicaid Information Center (SMIC). The purpose of the SMIC project is to serve as a central source of information concerning cost containment strategies adopted by individual state Medicaid programs.

This A Catalogue of State Medicaid Program Changes is intended to serve as a complete and easy-to-use reference document which provides summaries of individual states' Medicaid cost containment activities. Such a guide should allow state officials to readily access the experience and expertise of other states that have pursued specific policy initiatives and expand the range of potential policy alternatives available for consideration by a state. The Catalogue was originally published in September 1981, and has been updated several times over the past two years. This document contains abstracts of those policy changes implemented or proposed during 1982 and 1983. The organization of this Catalogue differs slightly from previous editions, as described in the next section of the document. New items not appearing in previous editions of the Catalogue are identified by asterisks in the left margin of this document.

Both primary and secondary sources of data on state cost containment activities have been consulted in the preparation of the Catalogue, and every effort has been made to verify all information directly with each state agency. In order to provide as full and complete a data base as possible, information on state-initiated changes which have expanded the scope of their programs also is presented in this document, as are some of the more significant changes which recently have been proposed but as yet have not been implemented. Program modifications required of all states, as the result of changes in federal requirements (e.g., mandatory coverage of rural health clinics), have not been included. The estimated dollar impact of particular program changes is presented when states have provided this information.

Since the Catalogue is structured for easy revision, states will be provided on a regular basis with data on new state initiatives. This will be an especially important feature as states make use of greater policy latitude provided by recent changes in federal law. We have received a very strong, positive response to the publication of A Catalogue of State Medicaid Program Changes. It is hoped that the information presented in this Update will prove useful to state officials in their efforts to control escalating Medicaid expenditures while maintaining access to needed health services for the nation's poor.

March 1984



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## HOW TO USE THIS DOCUMENT

Presented in this Catalogue are data on individual state Medicaid program changes which were implemented or proposed during 1982 and 1983. The organization of this edition of the Catalogue differs slightly from previous editions. Abstracts describing these changes are included under one or more of the four major sections of the Catalogue, which are the following:

- I. Services
- II. Administration and Management
- III. Eligibility
- IV. Alternative Methods of Service Delivery/Program Management

Under Section I, Services, abstracts are listed according to the particular services a policy change effects. Under each service, abstracts are presented under one of the following subheadings, according to the nature of the policy change:

- A. Amount, Duration, and Scope
- B. Utilization Controls
- C. Reimbursement

A directory of the services to be found in Section I as well as the subheadings for Sections II, III, and IV are presented in the Table of Contents which appears at the beginning of this document.

In order to explain the general format for all Catalogue abstracts, a sample abstract of a state program change is presented below:

### NEW ITEM IDENTIFIER

	STATE ID	STATUS CODE	DATE PROPOSED OR IMPLEMENTED	IMPACT CODE	DESCRIPTION OF CHANGE
*	WI	*A	7/83	(-)	Wisconsin began requiring second opinions for cataract extractions done in conjunctions with intraocular lens implants.

The **NEW ITEM IDENTIFIER** is represented by an asterisk in the left margin at the beginning of an abstract. It identifies the abstract as a new entry which has not appeared in previous editions of the Catalogue.

The **STATE ID** is a two-character code which identifies the state in which the program change was implemented or proposed. A listing of these codes is presented at the end of this section.

The **STATUS CODE** indicates the latest reported status of a particular program change. The codes are:

- \*A Change adopted or implemented by state
- \*C Program change being considered by state
- \*P Program change formally proposed by a state agency, pending a final decision
- \*X Proposal dropped

The **DATE CODE** indicates the year and, when possible, the month in which a particular change first was proposed or implemented.

The **IMPACT CODE** indicates whether the change resulted or is expected to result in an increase (+) or decrease (-) in program expenditures.

The **DESCRIPTION** is a brief statement of the program change. When the abstract describes a bill introduced in the state legislature the bill number is presented in parentheses at the beginning of the description. Additional information, such as the estimated dollar impact, is included when available.

Within each subsection, abstracts are listed alphabetically by state. Where there is more than one abstract for a given state, the listings are arranged in chronological order beginning with the most recent change.

In addition to the four major chapters which contain abstracts of state program changes, a section is included on **Selected State Medicaid Program Characteristics**, which contains tables summarizing certain current aspects of all state Medicaid programs, regardless of the date these policies and procedures first were implemented.

## STATE ABBREVIATIONS

Alabama	AL	Nebraska	NE
Alaska	AK	Nevada	NV
Arizona	AZ	New Hampshire	NH
Arkansas	AR	New Jersey	NJ
California	CA	New Mexico	NM
Colorado	CO	New York	NY
Connecticut	CT	North Carolina	NC
Delaware	DE	North Dakota	ND
District of Columbia	DC	Northern Marianas	TT
Florida	FL	Ohio	OH
Georgia	GA	Oklahoma	OK
Guam	GU	Oregon	OR
Hawaii	HI	Pennsylvania	PA
Idaho	ID	Puerto Rico	PR
Illinois	IL	Rhode Island	RI
Indiana	IN	South Carolina	SC
Iowa	IA	South Dakota	SD
Kansas	KS	Tennessee	TN
Kentucky	KY	Texas	TX
Louisiana	LA	Utah	UT
Maine	ME	Vermont	VT
Maryland	MD	Virgin Islands	VI
Massachusetts	MA	Virginia	VA
Michigan	MI	Washington	WA
Minnesota	MN	West Virginia	WV
Mississippi	MS	Wisconsin	WI
Missouri	MO	Wyoming	WY
Montana	MT		





# SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS

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## 1. ADMINISTRATIVE METHODS

**Compiled by:** The State Medicaid Information Center  
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**Key:** y = Yes  
n = No  
p = Proposed

d = Demonstration Basis  
c = Certain Procedures, Services, or Recipient Categories

National Governors' Association  
444 North Capitol Street  
Washington, DC 20001  
(202) 624-5354

### III. UTILIZATION CONTROLS

**Compiled by:** The State Medicaid Information Center  
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**Key:** y = Yes  
n = No  
p = Proposed

d = Demonstration Basis  
c = Certain Procedures, Services, or Recipient Categories

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Information Center  
National Governors' Association  
444 North Capitol Street  
Washington, DC 20001  
(202) 624-5343



SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS  
1983

II. UTILIZATION CONTROLS  
(CONTINUED)

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	GU	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT
1. Cost-sharing on:																												
Audiological Services																												
Chiropractic Services																												
Clinic Services																												
Dental Services																												
Dentures																												
Drugs	V <sup>a</sup>		50¢ <sup>†</sup>		\$1 <sup>†</sup>			50¢		5% <sup>c</sup>							\$3 <sup>d</sup>	\$1 <sup>d</sup>										
Emergency Rooms					\$5 <sup>†</sup>			\$2									\$2 <sup>d</sup>	\$3 <sup>d</sup>										
Eyeglasses																												
Hearing Aids										5% <sup>c</sup>							\$3 <sup>d</sup>											
Inpatient Hospital Services			55-15 <sup>†</sup>												V <sup>e</sup>													
Medical Supplies & Equipment																												
Optometric Services																	\$2 <sup>d</sup>											
Outpatient Hospital Services																	\$2 <sup>d</sup>	\$1 <sup>d</sup>										
PT, OT, Speech/Hearing Therapy																	\$1 <sup>d</sup>											
Physician Services																												
Podiatric Services			50¢ <sup>†</sup>														\$1 <sup>d</sup>	\$1										
Private Duty Nursing																												
Prosthetic Services																												
Psychiatric Services																	\$2 <sup>d</sup>											
Psychologist Services																												
Rehabilitative Services																	\$2 <sup>d</sup>	\$1										
Transportation																	\$2 <sup>d</sup>	\$1 <sup>s</sup>										

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(202) 624-5363

Key: V = Variable Copayment Schedule.  
See following page for explanatory footnotes.

SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS  
1983

II. UTILIZATION CONTROLS  
(CONTINUED)

	NE	NH	NJ	NY	PA	RI	SD	TX	UT	VA	WA	WI	WY	Total all states
I. Cost-sharing on:														
Audiological Services												\$1		3
Chiropractic Services							50¢					50¢		7
Clinic Services	\$1 <sup>m</sup>						5% <sup>p</sup>			\$1		r		5
Dental Services	\$2 <sup>m</sup>						\$1 <sup>o</sup>					r		9
Dentures	\$3						\$3					\$3		6
Drugs	\$1	75¢					50¢					50¢ <sup>r</sup>		19
Emergency Rooms														3
Eyeglasses	\$3						\$1					r		8
Hearing Aids												\$3		5
Inpatient Hospital Services							\$25					\$3 <sup>r</sup>		6
Medical Supplies & Equipment							p					r		3
Optometric Services							\$1					r		9
Outpatient Hospital Services							5% <sup>p</sup>					\$2		5
P.T., O.T., Speech/Hearing Therapy												50¢ <sup>r</sup>		3
Physician Services	\$1						\$1							5
Podiatric Services														6
Private Duty Nursing	\$1													0
Prosthetic Services	\$3						5%							3
Psychiatric Services												50¢ <sup>r</sup>		1
Psychologist Services												50¢ <sup>r</sup>		3
Rehabilitative Services														2
Transportation	\$3/1 <sup>n</sup>											\$2 <sup>r</sup>		4

Compiled by: The State Medicaid Information Center  
Key: V = Variable Copayment Schedule.  
See following page for explanatory footnotes.

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**Footnotes for Table II. Utilization Controls,  
Section K. Cost-Sharing**

- a. Alabama has a variable copayment on drugs, based on the drug ingredient cost (minus the \$2.75 dispensing fee):

<u>DRUG COST</u>	<u>COPAYMENT</u>
\$ .01 - 7.25	\$ .50
\$ 7.26 - 22.25	\$1.00
\$22.26 - 47.25	\$2.00
\$47.26 +	\$3.00

- b. The state has a sliding scale for copayments in line with the following federally allowed maximums cited in 42 CFR 447.54(a)(3):

<u>PROGRAM COST</u>	<u>COPAYMENT</u>
\$10.00 or less	\$ .50
\$10.01 - 25.00	\$1.00
\$25.01 - 50.00	\$2.00
\$50.01 +	\$3.00

- c. Florida has a copayment of 5 percent on the total treatment cost of providing dentures to individuals 21 and over. For hearing aids, the state assesses a 5 percent copayment on the dispensing service, and a 5 percent copayment on the hearing aid itself for persons 21 and over.
- d. Iowa's \$1 copayment listed under "P.T., O.T., Speech/Hearing Therapy" is for physical therapy only. The \$2 copayment listed under "Transportation" is for ambulance service only. Exemptions include individuals under 21 and all services to pregnant women.
- e. Illinois established an inpatient hospital copayment in July 1983 for medically and categorically needy recipients, according to the following schedule:

<u>PER DIEM WHICH STATE PAYS HOSPITAL</u>	<u>COPAYMENT</u>
\$325 +	\$3 per day
\$275.01 - 324.99	\$2 per day
\$275.00 or less	NONE

- f. West Virginia's copayment schedule for drugs is:

<u>PROGRAM COST</u>	<u>COPAYMENT</u>
Up to \$10.99	\$ .50
\$11.00 and above	\$1.00

- g. North Dakota charges a \$3.00 copayment for replacement of eyeglasses due to loss or breakage.
- h. All individuals under 21 are exempt from the copayments.



- i. Copayments on the indicated services for Medi-Cal recipients were implemented on May 10, 1982, under an 1115 waiver. The emergency room copayment is charged only in cases of inappropriate use. Federal waivers were granted in order to make certain exceptions. Children and women seeking perinatal care are exempt from the copayments on emergency room and outpatient hospital services. Additionally, nursing home residents and foster care children are exempt from the latter. Those groups exempt from the drug copayment are: children under 12, the aged, those with chronic conditions requiring multiple prescriptions, inpatients in a health facility, and Medicare recipients.
- j. The copayment is paid only by medically needy recipients.
- k. North Carolina's copayment for rehabilitative services is for non-hospital dialysis only.
- m. In Nevada, the \$2.00 copayment on dental services is charged for the initial dental exam only. The \$1.00 copayment for clinic services is limited to mental health outpatient services. Nevada charges a copayment of \$3.00 per trip for ambulance services, \$2 for medi-van, and \$1.00 for taxi services.
- n. Missouri implemented a variable copayment for the indicated services in 1981. See FOOTNOTE b for the sliding scale. On July 12, 1982 the state implemented a copayment for drug prescriptions: For a prescription of up to \$10.99, the charge is 50¢; for a prescription of \$11 or more, the charge is \$1.00. In February 1983, the state implemented a \$10 copayment on inpatient hospital admissions and a \$3 copayment on outpatient emergency room visits (\$2 for facility and \$1 for professional services).
- o. South Carolina imposes a \$1 copayment on emergency dental services, per procedure, for individuals 21 years and older.
- p. South Dakota imposes coinsurance of 5% on non-emergency outpatient hospital services. A copayment of \$1 is imposed on medical supplies, and a 5% coinsurance charge is imposed on medical equipment. The 5% coinsurance on clinic services is charged for mental health center services only.
- q. Michigan imposes a 50¢ copayment on all drug prescriptions except for those drugs with MAC limits. Individuals under 21 are exempt.
- r. For clinic services, Wisconsin charges \$2 per rural health clinic visit and 50¢ per day for medical day treatments. For dental services, it charges 50¢ per diagnostic service, \$2-3 per orthodontic service, and \$1 per other non-emergency service. Drug copayments are 50¢, up to a maximum of \$5 per calendar month. Eyeglass copays are \$3 per pair, \$2 for replacements, and 50¢ for repairs. Inpatient hospital charges are \$3 per day, not to exceed \$75 per stay. The disposable medical supply copayment is 50¢; and the DME copay is \$1. For optometric services: an annual exam is \$2, the follow-up exam or testing is 50¢, visual therapy and training or low vision services is \$1, and contact lens service is \$3. Physical therapy, occupational therapy and/or speech and hearing therapy are 50¢ per 15 minutes, but none is collected over 30 hours or \$1,500 of equivalent care per therapy type per calendar year. Psychotherapy and alcohol and other drug abuse therapy is 50¢ per 15 minutes, but none is charged for over 15 hours or \$500 of equivalent care per calendar year. Under transportation, there is a \$2 non-emergency ambulance copayment. Other copayments include \$3 per month for community care organization services and \$1 per screening for EPSDT recipients 18 and older.



- s. Copay on non-emergency ambulance only.
- t. Arizona, which has a three-year demonstration program established as an alternative to traditional Medicaid systems, charges a 50¢ copayment on physician visits for the initial, patient-initiated visit only. A copayment imposed by hospitals on all non-emergency surgery is \$5 for the categorically needy and \$15 for the medically needy and medically indigent.
- x. Montana allows each recipient two free prescriptions per month and, beginning with the third, he or she pays 50¢ per prescription.
- y. Virginia charges copayments to the medically needy only for inpatient hospital services, outpatient hospital services and physician services. A copayment is charged on optometric examinations. The copayment on drugs is 50¢ for prescriptions of \$10 or less and \$1 for prescriptions of more than \$10. Individuals under 21 are exempt.

### III. REIMBURSEMENT

Compiled by: The State Medicaid Information Center  
National Governors' Association

Key: y = Yes  
n = No  
p = Proposed

d = Demonstration Basis  
c = Certain Procedures, Services, or Recipient Categories

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444 North Capitol Street  
Washington, DC 20001  
(202) 624-5354



NOTES  
HOSPITAL REIMBURSEMENT: SPECIAL ISSUES  
SELECTED STATE CHARACTERISTICS

1. Alabama: A hospital whose Medicaid utilization rate exceeds one standard deviation above the mean Medicaid utilization rate of all in-state hospital providers in the Alabama Medicaid program, and whose originally calculated per diem (excluding education and fixed costs) shall exceed the ceiling rate for the class in which it falls.
2. Alabama: Refer to AL, Med Reg. Ch. 23, Subchapter G, part 1, pgs 6 and 7.
3. Kentucky: 20% or more of total occupancy must be indigent patients.
4. Kentucky: Maximum rate set at 120% of median.
5. Massachusetts: For chronic hospitals relief begins when 16% or more of patients served by hospital are publicly aided, free care or bad debt. For acute hospitals, relief begins when 68% or more of revenues are attributable to Medicare/Medicaid/bad debt/free care/state or local subsidy.
6. Massachusetts: For chronic hospitals, per diem rate for inappropriately placed patients adjusted upwards, depending on hospital's percentage of low-income patients and hospital's conformity with discharge planning guidelines. For acute hospitals, free care added to definition of Medicaid-recognized cost in qualifying hospitals.
7. Michigan: 25% or more Medicaid volume.
8. Michigan: A high volume Medicaid hospital is allowed a one percent increase in the ppd limitation for each \$ Medicaid patient days exceeds 25% of total patient days.
9. Michigan: HBPs costs are added into "included" and "operating" costs and are limited by indices and percentiles of ppd costs.
10. Minnesota: No, currently; definition will be 15%. Adjustment to percentage over 15% for inflation-related increases.
11. Mississippi: Medicaid utilization of at least 125% statewide average, and subject to 80th percentile and at least minimum occupancy for class.
12. Mississippi: Rate adjusted for lesser of waiver of 80th percentile cap or operating component times the percentage of occupancy above class minimum.
13. Missouri: 20% or more Medicaid days as a percentage of actual total service days; 60% patient days for government-sponsored programs as a percentage of total actual service days; \$1 million annual Medicaid reimbursement.
14. Missouri: Decision is based on review of cost and claim data for prior year, changes in utilization, and supporting documentation from facility.
15. New York: Hospitals with weakened financial position, as determined by examining bad debts and charity care, receive money from pool funded by major payers.
16. New York: Part 86-1.42 of state regulations.



17. North Carolina: During the past year, we granted rate increases to hospitals that had a combined Medicaid/Medicare case load of 65% or greater.
18. Pennsylvania: The hospital's percentage of medical assistance (MA) occupancy must be greater or equal to one standard deviation above the mean percentage, or the percentage of MA days to total MA days must be greater or equal to one standard deviation above the mean for all hospitals.
19. Texas: Texas Medicaid Program applies Medicare regulations for reimbursement of hospital based physicians. Regulations can be found in Medicare Provider Reimbursement Manual (HIM-15-1), Chapter 21, Costs Related to Patient Care, Sec. 2108, Provider Based Physician Services, p. 21-5.
20. Virginia: In excess of 8% Medicaid utilization.
21. Virginia: Those providers receive a 1% adjustment in their ceiling for each percentage the utilization exceeds 8%, up to maximum of 30%.
22. Washington: A hospital whose medical assistance admissions are equal to or higher than 25 percent of its total admissions.
23. Washington: The Wage Component Limitation is not applied to hospitals serving a disproportionate number of low-income patients with special needs, as defined.
24. Washington: No. As a matter of long-standing policy, hospital based emergency room physician services may not be combined-billed with the hospital charges to the medical assistance program.



C. NURSING HOME REIMBURSEMENT  
CHART I  
CAPITAL REIMBURSEMENT

The Value of the Home										State Sets	
Historic Costs	Historic Costs		Market Value			Buyer and Seller Must be Unrelated		Depreciation Permitted			
	From Date of Construction	From Date of Last Sale	Other	Replacement Costs	Market Value	Price Limits	Other	Depreciation Permitted	Straight Line	Accelerated	
AL	Yes			Yes(1)				Yes(2)	Yes	AL	
AK(3)	Yes								Yes	AK	
AZ										AZ	
AR	Yes	Yes						Yes(4)	Yes	AR	
CA		Yes	(5)						Yes	CA	
CO	Yes	Yes							Yes	CO	
CT	Yes	Yes							Yes	CT	
DE	Yes	Yes								DE	
DC	Yes	Yes			Yes		Yes(6)		Yes	DC	
FL	Yes	Yes		Yes(8)				Yes(9)	Yes	FL	
GA	Yes	Yes		Yes	Yes(11)				Yes	GA	
HI	Yes	Yes(10)		Yes					Yes	HI	
ID	Yes	Yes	Yes(15)	Yes(16)					Yes	ID	
IL	Yes	Yes			Yes	Yes(17)		Yes(18)	Yes	IL	
IN	Yes	Yes			Yes		Yes(20)		Yes	IN	
IA	Yes	Yes	Yes(21)		Yes			Yes(22)	Yes	IA	
KS	Yes	Yes	Yes(23)		Yes				Yes	KS	
KY	Yes								Yes	KY	
LA										LA	
ME	Yes	Yes		Yes(25)	Yes	Yes(27)	Yes(28)		Yes	ME	
MD			Yes(32)	Yes	Yes	Yes(30)		Yes(31)	Yes	MD	
MA	Yes	Yes	Yes(33)					Yes(36)	Yes	MA	
MI	Yes	Yes		Yes(34)				Yes(37)	Yes	MI	
MN	Yes	Yes			Yes				Yes	MN	
MS	Yes	Yes			Yes	Yes(38)			Yes	MS	
MO	Yes	Yes(39)			Yes		Yes(40)	Yes(41)	Yes	MO	
MT										MT	
NE	Yes	Yes			Yes				Yes	NE	
NV	Yes	Yes			Yes	Yes(42)			Yes	NV	
NH	Yes	Yes					(44)		Yes	NH	
NJ	Yes	Yes		Yes(43)					Yes	NJ	
NM	Yes(45)	Yes	Yes						Yes	NM	
NY	Yes	Yes							Yes	NY	
NC	Yes	Yes							Yes	NC	
ND	Yes	Yes							Yes	ND	
OH	Yes	Yes			Yes	Yes(46)		Yes(48)	Yes	OH	
OK(49)										OK	
OR	Yes	Yes(50)							Yes	OR	
PA		Yes					Yes(51)	Yes(52)	Yes	PA	
RI	Yes	Yes		Yes	Yes	Yes(53)			Yes	RI	
SC	Yes	Yes		Yes(55)	Yes	Yes(56)		Yes(57)	Yes	SC	
SD	Yes	Yes			Yes				Yes	SD	
TN	Yes	Yes			Yes	Yes		Yes	Yes	TN	
TX	Yes	Yes			Yes	Yes			Yes	TX	
UT	Yes		Yes(58)						Yes	UT	
VT	Yes	Yes(59)			Yes	Yes(60)	Yes(61)		Yes	VT	
VA	Yes	Yes			Yes	Yes(62)	Yes	Yes(64)	Yes	VA	
WA	Yes						Yes(66)		Yes	WA	
WV								Yes(67)		WV	
WI	Yes	Yes						Yes(68)	Yes	WI	
WY	Yes	Yes							Yes	WY	

## C. NURSING HOME REIMBURSEMENT

### CHART 1 NOTES CAPITAL REIMBURSEMENT

1. Alabama: If ongoing facility is sold, replacement costs are used to determine maximum basis for new owner.
2. Alabama: \$15,500, based on historic trends, revised annually.
3. Alaska: Presently in transition to a prospective payment system. Survey responses reflect interim: 7-1-83 through 6-30-84.
4. Colorado: Only so far as lease of facility is concerned. Rental costs are limited to a median cost. Median is computed using costs of owned facilities. Rental costs limited by median for year lease entered and increases/decreases in property costs over lease year. (See Regs. 8.446)
5. Connecticut: In limited situations where increase in value for sales is allowed, historic costs are updated to date of sale.
6. Florida: For capital reimbursement purposes, the lower of purchase price, market value, and adjusted historic cost is used.
7. Florida: With special approval, the double declining balance or sum of the year's digits is allowed.
8. Georgia: See Regs Ch. 1000, x-9, 1002.5.
9. Georgia: Ch. 1000, pgs. x-1-7, State Health Planning also sets maximum values on the costs of beds.
10. Hawaii: Cost may not exceed lower of depreciated replacement or market value.
11. Hawaii: For donated assets.
12. Hawaii: Buyer and seller may not be related by common ownership or control.
13. Hawaii: a) For assets acquired before 8/70, declining balance (up to 200% of straight-line rate) or sum of year's digits. b) For assets acquired after 7/70, declining balance (up to 150% of straight-line rate) under limited circumstances. See regs HIM 15-1, Sec. 116C.
14. Idaho: Yes, if original owner is current owner.
15. Illinois: The historic cost at the latter of the date of construction or date of last purchase prior to July 1, 1977 is used.
16. Illinois: The historic cost net of accumulated depreciation is inflated to the rate year according to the change in construction cost index.
17. Indiana: A table of maximum property values per bed was established on 7-1-76. The values are increased semiannually, based on increases in construction costs.

18. Indiana: \$20,000 per bed is allowed for acquisition on 9-1-82, adjusted semiannually in accordance with the change in the R.S. Means Construction Index.
19. Indiana: Any depreciation method is acceptable as long as it is in accordance with the GAAP. Depreciation is a component of the Capital Return Factor, which is used to reimburse the provider for the use of facilities and equipment.
20. Iowa: Lower of appraised value (depreciated) or purchase price.
21. Kansas: See subparagraph (bb) and (cc) pages 6 and 7 of Sec. 30-10-12 and (iv) on page 11 of Sec. 30-10-13.
22. Kansas: The property cost center is limited to the amount representing the 85th percentile of the property costs of providers participating in the program. The current limits are: SNF \$6.72, ICF \$5.59, ICF/MR \$7.21.
23. Kentucky: Depreciable basis of seller plus 2/3 of 1% per month of gain is added for each month the seller has owned facility. Must be unrelated parties.
24. Kentucky: If the cash flow of a facility does not meet current mortgage payments, it may utilize 150% declining balance.
25. Maine: Applies if replacement cost, adjusted for straight-line depreciation on existing facilities, is less than the selling price.
26. Maine: One time sales to a related party if the seller is 55+ years old and removes him/herself from the industry.
27. Maine: On sales of existing facilities it must be lower than historic or replacement cost to apply.
28. Maine: For sale of existing facilities: historical cost is limited to the seller's historical cost inflated by the CPI index for all items from the date of purchase to the date of sale, if it is lower than the replacement cost and market value.
29. Maine: Only on energy efficient improvements.
30. Maryland: See Intermediate Care Facility Services regulations, .07E(11), October 1, 1982.
31. Maryland: For FY 83 based on \$22,000, 1 bed in March 1981 inflated by the index in Intermediate Care Facility Services regulations, .07E(9), October 1, 1982.
32. Massachusetts: Since 1976, facilities valued at 1976 rate.
33. Michigan: Cost limited to lesser of: a) purchase price, b) depreciated replacement cost, or c) fair market value.
34. Michigan: Independent appraiser chosen by provider.
35. Michigan: See Medicare principles of reimbursement.



36. Michigan: Ceiling is implicit. Per diem plant cost (interest depreciation, property taxes, rent) limit is based on the average (from a survey of homes opened between 1975 and 1977) per diem cost of a recently constructed, prudently financed facility (assuming 100% occupancy, 25% equity, no working capital, and PRM and 104.17 useful lives).
37. Minnesota: Depends upon purchase value.
38. Mississippi: Certificate of need review by health planning agency.
39. Missouri: Prior to 7-1-82. After that date, no recognition for change of ownership.
40. Missouri: Capital rate established for homes entering program after March 18, 1983 based upon Dodge Construction System plus 8% for soft cost.
41. Missouri: Dodge Construction Index, times square footage of facility, not to exceed 325 sq. ft. per bed divided by the number of beds.
42. Nevada: No common ownership or control.
43. New Jersey: Appraised in '77 replacement costs, less wear and tear, subject to reasonableness limits on square feet and appraised value per square foot.
44. New Jersey: 23 rules are established on a dual trade, historical (unscreened) versus capital facilities allowance (screened).
45. New Mexico: Although value of depreciable assets is based upon historic cost at construction or acquisition with the following exceptions:
  - a. If an existing facility is leased or sold, the allowable facility cost of the new provider is limited to the lesser of actual costs or the 80th percentile facility costs in the previous year of all participating providers who provide the same level of care which own and operate their own facilities and do not incur rental expense which is more than 20% of total facility costs.
  - b. Newly constructed facility costs are limited to those applicable to the median cost of constructing a nursing home as listed in an index acceptable to the Department. At present the Construction Cost Guide published by Robert S. Means Co. is used.
46. Ohio: Lack of common ownership/control and/or lack of family relationship.
47. Ohio: Unrelated buyer may revalue assets based upon purchase price, but is subject to screening.
48. Ohio: Maximum dollar value ranges from \$2.50 to \$6.45 per day based on date of original nursing home licensure and original per bed construction costs.
49. Oklahoma: State establishes reimbursement rate through negotiation with the Nursing Home Association. The rate, for the most part, is based on the prior year's rate of payment, adjusted for inflation or any increase in required standards or services.
50. Oregon: Only for original owner, not subsequent owners.

51. Pennsylvania: Newly constructed facilities are valued at their cost, less any start-up costs. The cost basis (value of the home) for purchased facilities shall be the lesser of the purchase price or the fair market value based on the lesser of at least two bonafide appraisals at the time of sale and less any straight-line depreciation by the prior owner.
52. Pennsylvania: \$22,000 per bed and fixed equipment.
53. Rhode Island: Blood, marriage, or financial interest.
54. Rhode Island: Limited to the lower of a) fair market value, b) purchase price, c) reproduction costs depreciated over useful life of the assets, d) original cost plus a return of 7% per year from date of acquisition.
55. South Carolina: Medicare guidelines limit maximum recognition of cost at replacement value.
56. South Carolina: Medicare principles.
57. South Carolina: Cost of capital limited to \$7.79 per patient day.
58. Utah: Property recognized in the rate as of 3/27/81. Approximately 40% cost inflated by CPI-U less mortgage index each year.
59. Vermont: Cost to purchaser at date of purchase by the owner.
60. Vermont: Not a business associate, family relation, or spouse.
61. Vermont: Limit is agreed upon sales price in the sales agreement, reconstruction cost, or the appraisal value, whichever is less.
62. Virginia: Buyer and seller must not have common interests in other activities.
63. Virginia: The lower of the purchase price or fair market value for sale of homes owned five years or more.
64. Virginia: Maximum is established each year in January for building and fixed equipment costs based upon Dodge Construction System cost. As of January 1, 1983, the amount will be \$25,129.00 per bed plus 7% for financing costs.
65. Washington: On equipment only, declining balance, sum of the year's digits. Declining balance is limited to 150% of straightline.
66. West Virginia: Standard Appraised Value — developed by West Virginia for reimbursement of nursing home current reproduction cost adjusted for observed depreciation capitalized based upon type of incorporation (profit or nonprofit) and date of original financing.
67. West Virginia: Only through the appraisal value technique. (See previous note).
68. Wisconsin: \$17,600/1977 amount, indexed to current sum by Engineering News Record from year of facility construction.



C. NURSING HOME REIMBURSEMENT  
CHART 2  
CAPITAL REIMBURSEMENT

	Depreciation Must Be Funded	Useful Life			Interest Expenses Recognized	State Sets the Rate It Will Pay	Actual Expenses Paid	Interest Expenses Reimbursed			
		30 Years	35 Years	40 Years				Prevailing Rates	Prevailing Rates to a Ceiling	Medicare Rate of Return	Other
AL				Yes	Yes		Yes	Yes(1)			AL
AK(2)				Yes	Yes						AK
AZ							(n)				AZ
AR					Yes						AR
CA					Yes		Yes				CA
CO		Yes			Yes		Yes				CO
CT					Yes		Yes			Yes	CT
DE					Yes			(7)			DE
DC				Yes(8)	Yes		Yes	Yes(9)			DC
FL					Yes		Yes		Yes(11)	Yes(12)	FL
GA					Yes		Yes				GA
HI		Yes			Yes		Yes	Yes(15)			HI
ID		Yes			Yes		Yes				ID
IL		Yes			Yes		Yes				IL
IN					Yes	Yes	Yes				IN
IA				Yes	Yes		Yes		Yes		IA
KS					Yes		Yes				KS
KY					Yes		Yes	Yes(22)			KY
LA					Yes		Yes				LA
ME		Yes		Yes	Yes	Yes(23)	Yes	Yes(23)			ME
MD				Yes	Yes	Yes(24)	Yes	Yes(24)	Yes(25)		MD
MA					Yes	Yes	Yes		Yes(27)		MA
MI					Yes		Yes				MI
MN			Yes	Yes	Yes	Yes(29)	Yes				MN
MS					Yes		Yes	Yes(30)	Yes		MS
MO				Yes	Yes		Yes			Yes(31)	MO
MT					Yes		Yes	Yes			MT
NE				Yes	Yes		Yes	Yes			NE
NV					Yes		Yes	Yes			NV
NH					Yes		Yes	Yes			NH
NJ					Yes		Yes			Yes	NJ
NM					Yes		Yes	Yes(36)			NM
NY	Yes(37)			Yes	Yes	Yes(38)	Yes	Yes(39)			NY
NC					Yes		Yes				NC
ND					Yes		Yes			Yes	ND
OH				Yes	Yes		Yes		Yes		OH
OK(44)					Yes		Yes				OK
OR		Yes	Yes	Yes	Yes	Yes(47)	Yes	Yes		Yes(46)	OR
PA				Yes	Yes		Yes		Yes(48)		PA
RI					Yes		Yes		Yes(50)		RI
SC					Yes		Yes				SC
SD		Yes			Yes		Yes	Yes(52)			SD
TN					Yes		Yes	Yes(53)			TN
TX				Yes	Yes		Yes	Yes			TX
UT					Yes		Yes				UT
VT		Yes	Yes	Yes	Yes		Yes	Yes(58)			VT
VA			Yes	Yes	Yes		Yes		Yes(60)		VA
WA		Yes			Yes		Yes				WA
WV					Yes		Yes				WV
WI		Yes	Yes		Yes		Yes			(62)	WI
WY					Yes		Yes				WY

## C. NURSING HOME REIMBURSEMENT

### CHART 2 NOTES CAPITAL REIMBURSEMENT

1. Alabama: Alabama doesn't govern or try to control rates of interest. We reimburse historic costs based on actual transactions and the rate of interest at that time.
2. Alaska: Presently in transition to a prospective payment system. Survey responses reflect interim: 7-1-83 through 6-30-84.
3. Arkansas: The useful life depends on the type of structure – wood frame, concrete frame, etc. – range: 20-30 years.
4. Arkansas: The expense is an allowable expense on the cost report; facilities are reimbursed by the per diem for various levels of patient care.
5. Colorado: Depends on age of facility at the time of the purchase.
6. Colorado: Amount paid except that related parties receive to extent of prime rate additional due to refinancing disallowances.
7. District of Columbia: Interest incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made will be recognized.
8. Florida: Per AHA guidelines.
9. Florida: The rate of the debt instrument is used, if reasonable.
10. Georgia: If a transaction, the life is determined by the replacement cost appraisal; otherwise, use AHA guidelines for depreciation.
11. Georgia: Houses grouped by age and maximum property costs permitted.
12. Georgia: We use 1½ times the FHA rate; we currently have frozen it at 15.188% for return on equity.
13. Hawaii: 25 years masonry, woodframe residence, masonry and wood frame.
14. Hawaii: Necessary and proper HIM-15-I, Sec. 202.2 and 3.
15. Idaho: Reasonableness based upon intended use, i.e. – capital improvement vs. operating. Also based upon availability of other funds as demonstrated by rates obtained by similar facilities.
16. Illinois: A rate of return of 11.1% is paid on the updated investment in the nursing home. This covers all interest and depreciation expense in most cases, but there is no guarantee that all interest expense will be paid.
17. Indiana: (Refer to Chart 1, footnote #18). Present depreciation methods have nothing to do with Use Fee Calculations (Capital Return Factor), which has a specific Use Fee Life years designated.

18. Indiana: Maximum interest rate allowed in computing the Use Fee shall not exceed 1½% above the average yield to maturity of Federal Home Loan Mortgage Corporation whole loan purchase multi-family rate or the actual rate, whichever is lower.
19. Kansas: Varies: usually the same estimated life used for tax purposes.
20. Kansas: See Section 30-10-13-KS Ad. Regs., beginning pg. 12, 5(A), 5(B), 5(C), 5(D), 5(E) and 5(F).
21. Kentucky: Not established by state; use reasonableness test.
22. Kentucky: Rate paid by other homes in the area.
23. Maine: Determined through the certificate of need process.
24. Maryland: See Intermediate Care Facility Services regulations, .07E(8), October 1, 1982.
25. Massachusetts: The mean of each group of facilities (SNF freestanding, ICF 40 beds, ICF 40 beds) + standard deviation above mean is ceiling.
26. Michigan: Must be in compliance with S 104.17 of provider reimbursement manual.
27. Michigan: Implicit ceiling in plant cost limit.
28. Minnesota: On sale of existing facility, percentage of useful life applied to inputed 35 years.
29. Minnesota: Limited to allowable in excess of 9% but not to exceed 12%.
30. Missouri: Prime rate at the time of the loan.
31. Missouri: 12% on net equity.
32. Nebraska: Varies by type of construction.
33. New Hampshire: From 25 years to 40 years.
34. New Jersey: New construction - 40 years if constructed after 1959. Old construction - 25 years if constructed prior to 1960.
35. New Mexico: IE 1. through 4. - useful lines of depreciable assets are considered on an individual basis using the lines published in the AHA Audit Guide as guideline.
36. New Mexico: By comparison on an individual basis with rates available in the state on similar loans.
37. New York: Voluntary facilities only are required to fund the difference between depreciation and mortgage principle plus capital improvements. If depreciation is not funded, no reimbursement for depreciation is made.
38. New York: According to the market condition at the time financing is secured; in most cases, not to exceed FHA rate.



39. New York: Justification must be submitted by the home stating that this is the best rate which could be obtained. In most cases, FHA rate is guideline.
40. North Carolina: We use variable life based on the AHA standards published as "Estimated Useful Lives of Depreciable Assets."
41. North Dakota: 40 year useful life except on sale when useful life is used.
42. North Dakota: Actual as supported by an evidence of agreement that funds were borrowed and that repayment of interest and repayment of the funds are required.
43. Ohio: Building has 40 year useful life. All other equipment has useful life prescribed in IRS guidelines.
44. Oklahoma: State establishes reimbursement rate through negotiation with the Nursing Home Association. The rate, for the most part, is based on the prior year's rate of payment, adjusted for inflation or any increase in required standards or services.
45. Oregon: If leased, the lesser of estimated useful life and lease term.
46. Oregon: If between related parties limited to lesser of rate charged and current commercial rate less 10% rate portion applied in the ROE computation.
47. Pennsylvania: Maximum rate 3 points above prime at the time the funds are borrowed is an allowable expense, per the "Manual for Allowable Costs."
48. Pennsylvania: Remains at 3 points above prime at the time the funds are borrowed.
49. Rhode Island: Wood-25 years, Wood and Masonry-33 years, Masonry and Steel-40 years.
50. Rhode Island: Interest and depreciation limited to a maximum of 70th percentile of arrayed facilities of same level of care.
51. South Carolina: IRS guidelines depending on type of structure.
52. South Carolina: Necessary and prudent as well as reasonable.
53. South Dakota: Rate charged by lending agency.
54. Tennessee: Depends upon type of construction; e.g., for a wood frame, useful life would not be as long as for a steel frame.
55. Utah: Useful life may vary according to HIM-15 or prior agreement. At present we don't permit changes in the useful fee or in the depreciation expense.
56. Utah: Modified flat rate does not recognize changes in the mortgage, interest, or property valuation.
57. Vermont: We use the Estimated Useful Lives of Depreciable Hospital Assets, 1978 ed., by the American Hospital Association.
58. Vermont: Bank rate for commercial loans at time of financing.



59. Vermont: Prospective system, rate set by formula.
60. Virginia: Limits set by maximum rate set by the Virginia Housing Development Authority.
61. West Virginia: Standard Appraised Value sets a useful or expected life based upon type of construction.
62. Wisconsin: 1.25 x 3 year composite average cost of Hospital Investment Trust Fund.

C. NURSING HOME REIMBURSEMENT  
CHART 3  
CAPITAL REIMBURSEMENT

	Interest on Negative Net Equity		Interest on Negative Net Equity Paid		Penalties for Negative Interest Expenses	Sales of Home Reimbursed	Value of Homes Set By				Depreciation Recapture Provisions	Incentives Not to Sell
	Interest on Negative Net Equity Paid	All Interest Expenses Paid	Net Equity Interest Expenses a Ceiling	Net Equity Interest Expenses			Depreciated Replacement Costs	Income Value	Assessed Value	Market Value	Other	
AL	Yes		Yes(1)		(2)	Yes	Yes(3)		Yes		Yes(4)	AL
AK(5)						Yes						AK
AZ												AZ
AR						Yes				Yes(6)		AR
CA												CA
CO	Yes	Yes				Yes				Yes(7)		CO
CT						Yes					Yes	CT
DE						Yes						DE
DC	Yes	Yes				Yes				Yes(8)		DC
FL						Yes	Yes					FL
GA					Yes(12)	Yes				Yes(13)		GA
HI						Yes				Yes(14)		HI
ID	Yes	Yes				Yes	Yes(18)			Yes(16)		ID
IL						Yes						IL
IN						Yes(20)			Yes(21)	Yes(22)		IN
IA	Yes	Yes	Yes(26)		Yes(27)	Yes			Yes		Yes(24)	IA
KS	Yes	Yes				Yes	Yes(29)		Yes	Yes	Yes(28)	KS
KY	Yes	Yes				Yes						KY
LA						Yes	Yes(30)			Yes(31)		LA
ME					Yes						Yes(32)	ME
MD						Yes					Yes(33)	MD
MA						Yes(39)					Yes(34)	MA
MI	Yes		Yes(37)		Yes(38)	(43)	Yes			Yes(40)	Yes(35)	MI
MN						Yes					Yes(42)	MN
MS											Yes(44)	MS
MO	Yes		Yes							Yes(46)	Yes(47)	MO
MT												MT
NE	Yes	Yes				Yes				Yes	Yes(49)	NE
NV						Yes				Yes	Yes(50)	NV
NH						Yes			Yes	Yes(sales price)	Yes(51)	NH
NJ	Yes		Yes(52)			Yes						NJ
NM					(54)	Yes				Yes(53)	Yes(55)	NM
NY						Yes				Yes(58)	Yes	NY
NC		Yes(56)				Yes	Yes(57)			Yes(59)		NC
ND						Yes						ND
OH	Yes		Yes(60)			Yes				Yes(61)	Yes	OH
OK(63)												OK
OR						Yes				Yes		OR
PA	Yes		Yes			Yes				Yes(64)		PA
RI	Yes					Yes				Yes(65)		RI
SC	Yes	Yes				Yes	Yes				Yes(66)	SC
SD	Yes	Yes				Yes					Yes	SD
TN	Yes	Yes				Yes					Yes(69)	TN
TX						Yes						TX
UT						Yes						UT
VT						Yes	Yes			Yes(73)	Yes(74)	VT
V/A	Yes		Yes(75)			Yes(76)				Yes(72)	Yes	V/A
W/A	Yes		Yes(79)			Yes				Yes(77)		W/A
WV						Yes				Yes(80)		WV
WI	Yes	Yes				Yes				Yes(81)		WI
WY						Yes			Yes(reasonable)	Yes(83)		WY

## C. NURSING HOME REIMBURSEMENT

### CHART 3 NOTES CAPITAL REIMBURSEMENT

1. Alabama: Interest on mortgage amount equal to undepreciated replacement cost.
2. Alabama: Not unless loans were made to pay for unallowable expenses and also depleted working capital. In that case interest would be non-allowable.
3. Alabama: Maximum basis established using current per bed limit depreciated from date of construction.
4. Alabama: Medicaid portion reimbursed through per diem rate is recaptured for periods subsequent to July 1, 1977, limited to the gain on the sale or recapture, whichever is less. From eighth through fifteenth year of ownership, recapture is ratably forgiven.
5. Alaska: Presently in transition to a prospective payment system. Survey responses reflect interim: 7-1-83 through 6-30-84.
6. Arkansas: Purchase price.
7. Connecticut: In limited situations value of home increased at time of sale not to exceed depreciated value determination by Dodge Construction Index.
8. Florida: Lower of purchase price, market value, or adjusted historic cost.
9. Florida: Gain on sale is subject to the recapture provision of the provider reimbursement manual, HIM-15.
10. Florida: Buyer's allowable depreciable basis increases proportionately with length of time that seller owned the facility, limited by FMV.
11. Georgia: Georgia's new Property System will eliminate incentives. (Policies and Procedures Manual, Chapter 1000).
12. Hawaii: Interest expenses attributed to negative net equity are not reimbursed.
13. Hawaii: Sales price as per HIM 15-I, See Section 104.14B.
14. Hawaii: See regs Section 130--If the sale results in a gain, the amount of the gain is included in the determination of allowable cost and is limited to the amount of depreciation previously included in allowable costs.
15. Hawaii: Provision described in (14) above is incentive if his facility has appreciated, to avoid repayment of depreciation previously included in allowable costs.
16. Idaho: Purchase price supplemented by appraised documents.
17. Idaho: Sale occurs less than 5 years from date of acquisition recapture 100% from buyer. Sliding scale at 10% per year so that at 15 years, no recapture at all. Recapture will take place at the rate of 20% of original amount per year.

18. Illinois: The building cost as of 7-1-77 net of accumulated depreciation is updated for depreciation.
19. Illinois: In most cases the rate will be the same for the new owner as the old owner was receiving.
20. Indiana: Sale of facility is reimbursed, subject to certain limitations.
21. Indiana: Capital costs associated with the purchase of a facility are generally recognized but are limited in accordance with the Capital Return Factor. However, with sales between family members, a MAI appraisal is needed and historical costs are limited to the lower of the historical cost of the buyer or 90% of the appraisal.
22. Indiana: Seller's historical cost basis plus 1.0% of the difference between the purchase price or appraised value, if lower, and the seller's historical cost for each month the seller has owned the property.
23. Indiana: There is a penalty for selling the facility before eight years have passed.
24. Iowa: Any depreciation claimed since July 1, 1980, must be deducted.
25. Iowa: If the facility is fully depreciated we have no provision for ROE or investment.
26. Kansas: Property cost center limit--See item B on p. 1.
27. Kansas: If interest expense causes the property cost to exceed cost of center limit.
28. Kansas: See subparagraph (iii) gain on disposal of assets on page 10 of Sec. 30-10-13, Ks. Ad. Reg.
29. Kentucky: Seller's depreciable basis plus 2/3 of 1% per month of gain is added.
30. Maine: Only if lower than the fair market value, selling price, and CPI index formula.
31. Maine: Only if lower than the selling price, depreciated replacement cost, or the CPI index formula.
32. Maine: Depreciation paid on behalf of Medicaid patients recaptured to the extent of the gain on the sale.
33. Maine: Credits against depreciation recapture given for facilities owned more than 8 years, increased if facility owned over 15 years, and if owned over 25 years the depreciation recapture is eliminated.
34. Maryland: Rental paid in owner's equity; as equity increases so does payment.
35. Massachusetts: Until 1968 recapture against sale.
36. Massachusetts: No step up in base, no recognition of "fair market value."
37. Michigan: If resultant plant cost component is less than the plant cost limit.
38. Michigan: If plant costs exceed the plant cost limit, excess costs are not allowed.



39. Michigan: Only one sale is recognized (most recent) per five year period and costs paid must be less than (sales/resales) plant costs limit (determined as the provider's prior plant cost limit with the interest expense component revised to reflect market interest rates at the time of the sale).
40. Michigan: See 42 CFR-405.415(b)(2).
41. Michigan: The lesser of depreciated replacement cost, the market value, or the purchase price.
42. Michigan: To full extent allowed by Medicare principles of reimbursement.
43. Minnesota: Since 3-1-83.
44. Minnesota: The recapture is the lesser of the gain on sale or the depreciation expense since the adoption of DPN Rule 49 (11-02-72) Gross recapture is factored for the welfare portion to determine the net recapture. The net recapture is reduced by 1% for each month of continuous ownership since the date of acquisition.
45. Minnesota: Reduction in recapture and increase in return on equity function of years of ownership.
46. Mississippi: Certificate of need review by Mississippi Health Care Commission, a separate, autonomous health planning agency.
47. Mississippi: In part according to provisions of HIM-15 for periods under prospective rates.
48. Mississippi: ROE and adequate rates.
49. Nebraska: Lessor for Medicaid paid for depreciation on Medicaid share of gain.
50. Nevada: Selling price less all previous declared depreciation.
51. New Hampshire: Calculated according to Medicare guidelines, HIM-15, Sec. 132.
52. New Jersey: Medicare rate of return.
53. New Mexico: Allowable depreciation to new provider limited to the 80th percentile of per diem depreciation costs of other similar providers in the state.
54. New York: No interest or equity reimbursed.
55. New York: Sales are based on unreimbursed value of the original historical cost.
56. North Carolina: Payment subject to indirect rate limit; allowable amount subject to reasonableness.
57. North Carolina: Or market value, whichever is lower. Replacement cost is determined and home is depreciated based on age from date of construction using straight-line method.
58. North Carolina: Lower of market value or depreciated replacement.

59. North Dakota: Lower of replacement, fair market value, price paid. Lower of (1) current reproduction cost of assets, depreciated on a straight-line basis over its useful life to the time of sale, (2) price paid by the purchaser is fair market value of the facility at the time of sale.
60. Ohio: Interest on capital assets identified in #48, Chart 1. Interest on working capital is part of the flat rate for administrative and general services.
61. Ohio: New owner values at purchase price. If both assets and liabilities are purchased, considered ongoing business and assets may not be revalued.
62. Ohio: Recapture provision limited. Recovery provision for 10 years. Ceiling based upon original dated cost of construction is often too low to appeal to prospective buyers.
63. Oklahoma: State establishes reimbursement rate through negotiation with the Nursing Home Association. The rate, for the most part, is based on the prior year's rate of payment, adjusted for inflation or any increase in required standards or services.
64. Pennsylvania: The value of a purchased facility shall be the lesser of the purchase price or the fair market value based on the lesser of at least two bonafide appraisals at the time of sale less any straight-line depreciation by the prior owner.
65. Rhode Island: See I.A.3.b. (Chart 1, #46).
66. Rhode Island: Depreciation reimbursed to a provider from 1/1/72 through 12/31/76--full depreciation recovery. From 1/1/77 through 12/31/81 full depreciation recovery less 2½% credit for each year. From 1/1/82 through future periods, full depreciation recovery less 5% credit for each year.
67. Rhode Island: Recapture of depreciation plus limitations on sale price as addressed at I.A.3.b. acts as incentive not to sell.
68. South Dakota: Selling price is used for depreciation purposes.
69. Tennessee: Only if accelerated depreciation was used in the past.
70. Texas: Based upon acquisition cost to purchaser.
71. Utah: Payment rates not adjusted for buying and selling.
72. Vermont: Independent appraisal but not more than the agreed upon purchase price in the sales/purchase agreement.
73. Vermont: Lowest of purchase price, appraised value, or reproduction cost.
74. Vermont: Held less than 6 years, 100%; greater than 5 but less than 12 years, a percentage; nothing after 12 years.
75. Virginia: The present ceiling is 11.11%, based upon rates from the Virginia Housing Development Authority.

76. Virginia: If owned by the seller for five years or more and if related parties are not involved.
77. Virginia: The lower of the purchase price or fair market value.
78. Virginia: The actual amount paid by Medicaid up to the extent of the gain. Also, sale not recognized if owned less than five years.
79. Washington: Long term debt interest is subject to the property rate reimbursement lid (I.B.). Working capital interest is included in the administration's cost area, which is subject to an 85th percentile lid.
80. Washington: Depreciation based upon sale price plus interest subject to a lid based upon a regression performed on all contractors' property expense.
81. West Virginia: Standard Appraised Value does not change; rate of capitalization will change as per date of new financing.
82. West Virginia: Under the Standard Appraised Value the reproduction cost of a particular facility is re-valued each year.
83. Wisconsin: Depreciation doesn't change (original cost). Interest expense reflects current cost, lease expense allowed up to a lease maximum.

C. NURSING HOME REIMBURSEMENT  
CHART 4  
CAPITAL REIMBURSEMENT  
PROFITS AND RETURN ON EQUITY

Capital Reimbursement					Profits and Return on Equity				
State	Lease Payments Reimbursed	State Sets Limit on Payments	Lease Payments Reimbursed	Federal Tax Laws Changed Reimbursement	Profits are Reimbursed				Rate of Return
					Fixed Fee Per Patient Pay (PPD)	Variable Fee PPD to Maximum	Return on Equity Paid	Medicare Rate of Return	
AL	Yes	Yes(1)	Yes(3yrs)		Yes		Yes	Yes(2)	AL
AK(3)	Yes				Yes		Yes	Yes	AK
AZ									AZ
AR	Yes								AR
CA		Yes(4)					Yes	Yes	CA
CO	Yes								CO
CT(5)	Yes								CT
DE	Yes								DE
DC									DC
FL	Yes	Yes(6)			Yes	Yes(8)	Yes	Yes	FL
GA	Yes	Yes		Yes(7)	Yes		Yes	Yes(9)	GA
HI	Yes	Yes(10)					Yes	Yes	HI
ID	Yes	Yes(11)			Yes	Yes(12)		Yes	ID
IL	Yes	Yes(13)							IL
IN	Yes	Yes			Yes	Yes(16)	Yes	Yes	IN
IA	Yes	Yes(15)							IA
KS	Yes	Yes(17)			Yes	Yes(19)			KS
KY	(18)								KY
LA	Yes	Yes(20)	Yes(25 yrs)		Yes(21)	Yes(23)	Yes	Yes(22)	LA
ME					Yes		Yes	Yes(24)	ME
MD	(25)	Yes(28)			Yes	Yes(30)	Yes(26)	Yes	MD
MA	Yes(27)	Yes(32)		(29)	Yes	Yes	Yes(31)	Yes	MA
MN	Yes	(33)			Yes	Yes(34)			MN
MS	Yes	Yes		(35)	Yes(36)		Yes	Yes(12%)	MS
MO	Yes								MO
MT									MT
NE	Yes				Yes	Yes(37)	Yes	Yes(38)	NE
NV	Yes				Yes	Yes	Yes	Yes(39)	NV
NH	Yes								NH
NJ	Yes(40)	Yes(41)			Yes	Yes(42)	Yes	Yes	NJ
NM	Yes								NM
NY	Yes	Yes(43)					Yes	Yes	NY
NC	Yes	Yes					Yes	Yes(44)	NC
ND	Yes						Yes	Yes(8½%)	ND
OH	Yes	Yes			Yes	Yes(45)	Yes	Yes(46)	OH
OK(47)									OK
OR	Yes	Yes(48)			Yes	Yes(49)	Yes	Yes(50)	OR
PA	Yes	Yes(51)			Yes	Yes(52)			PA
RI	Yes	Yes(53)		Yes(54)	Yes	Yes(55)			RI
SC	Yes	Yes(56)			Yes	Yes(57)			SC
SD	Yes								SD
TN	Yes	Yes(58)			Yes	Yes(59)	Yes	Yes(9% on net equity) SD	TN
TX	Yes				Yes		Yes	Yes(60)	TX
UT	Yes	Yes(61)			Yes	Yes	Yes	Yes(62)	UT
VT	Yes	Yes					Yes	Yes	VT
VA		Yes(63)						Yes(10%)	VA
WA	Yes				Yes	Yes(64)	Yes	Yes	WA
WV	Yes	Yes(66)		(67)	Yes	Yes(68)	Yes(65)	Yes(69)	WV
WY	Yes				Yes	Yes	Yes		WY



## C. NURSING HOME REIMBURSEMENT

### CHART 4 NOTES CAPITAL REIMBURSEMENT

1. Alabama: Net lease: 12% of depreciated replacement value which is based on a per bed limit maximum.
2. Alabama: 112.5% of Medicare return.
3. Alaska: Presently in transition to a prospective payment system. Survey responses reflect interim: 7-1-83 through 6-30-84.
4. Colorado: Median is computed using costs of owned facilities. Rental costs limited by median for year lease entered and increases/decreases in property costs over lease year.
5. Connecticut: Facilities are reimbursed for property costs based on the fair rental value system whether owned or leased.
6. Florida: Ceiling is based on analysis of statewide survey of leased facilities.
7. Georgia: HIM requirements, cap on property cost center for total costs and not on the leasehold rights of individual accounts.
8. Georgia: See Policies and Procedures Manual, Chapter 1000.
9. Georgia: Frozen at 15.188%.
10. Hawaii: If lease is "virtual purchase" (HIM-15-I, Sec. 1103.1), maximum is what would have been paid to owner.
11. Idaho: New leases are based upon owner's cost = depreciation plus interest; old leases are based upon existing rates plus a reasonable annual increase as determined by a lease cost index.
12. Idaho: Efficiency incentive paid at 25% of difference between homes operating cost and percentile cap up to \$1.50 per day maximum.
13. Illinois: A ceiling is set at 125% of the median per diem lease cost for a geographic area.
14. Indiana: Return on equity is effected through a Capital Return Factor methodology.
15. Iowa: Actual owner's expense or \$500 per bed; currently revising this policy.
16. Iowa: If costs are below the maximum, an incentive factor is paid. Incentive is the rate that is  $\frac{1}{2}$  the difference of the 44th and 78th percentiles of facility costs.
17. Kansas: See prev. ref. Property Cost Ctr. limitation.
18. Kentucky: At historic cost. Leases are allowed for ICFs if entered into before 4-1-76 and for SNFs entered into before 12-1-79.

19. Kentucky: Varies inversely with allowable cost up to a maximum of \$2.25 per patient day.
20. Maine: Limited to cost of ownership.
21. Maine: On spending at a rate less than the prospective rate set.
22. Maine: 10% on annual average equity.
23. Maryland: 50% of the differences between cost and ceiling in each of two cost centers: administrative/routine and other patient care.
24. Maryland: For-profit facilities: .0988; nonprofit: .0790.
25. Massachusetts: Medicaid reimburses for actual costs.
26. Massachusetts: Calculated by using the net book value of the fixed assets minus long term liabilities.
27. Michigan: If lease contracted prior to 9/1/73.
28. Michigan: \$2.50 ppd, determined as the median (rounded) lease expense in 1983.
29. Michigan: Maybe: leases prior to 9/1/73, "rights" might have been included in lease cost; leases entered after 8/31/73, only the costs of interest depreciation and property taxes are reimbursed up to plant cost limit.
30. Michigan: "Plant profit" consists of up to 50¢ ppd of the difference between the plant cost and the classwide plant cost 80th percentile. "Variable profit" consists of up to \$1.00 ppd. of the difference between the variable costs and the classwide variable cost 80th percentile.
31. Michigan: In lieu of "plant profit."
32. Minnesota: The rental fee cannot exceed the total amount it would pay to the owner of the facility as interest, depreciation, and investment allowance.
33. Mississippi: Subject to certificate of need review.
34. Mississippi: Up to \$2.00/day to extent projected rate does not exceed class minimum.
35. Missouri: Court action has forced state to reimburse leasehold rights; under appeal at present.
36. Missouri: If a home operates below its rate, it keeps the profit.
37. Nebraska: Up to \$1.00 for-profit, .50¢ for nonprofit gov. (other than state-owned) for amounts under a capture, capture established to cover a percentile of Medicaid days. Percentile can change from year to year but will not go below 65th percentile/proposed to start 1/1/83.
38. Nebraska: 1½ times the average Hospital Trust Fund rate set annually/current proposed to end 7/31/81.

39. Nevada: Two times the average interest rate on special issues of public debt obligations issued to the federal Hospital Insurance Trust Fund.
40. New Jersey: Lease costs incurred as a result of a related party are not reimbursed.
41. New Jersey: Reasonable appraised value.
42. New Mexico: 50% of the amount per diem which the provider's total cost per diem is less than the current maximum reimbursement per diem rate adjusted for the provider's rate of cost increase compared with the increase in CPI.
43. New York: Per bed ceiling.
44. North Carolina: 14%.
45. Ohio: General and administrative actual costs + \$2.00 up to a flat ceiling.
46. Ohio:  $\frac{3}{4}$  this times the average of interest rates of special issues of public debt obligations issued to the federal Hospital Insurance Trust Fund for the cost reporting period.
47. Oklahoma: State establishes reimbursement rate through negotiation with the Nursing Home Association. The rate, for the most part, is based on the prior year's rate of payment, adjusted for inflation or any increase in required standards or services.
48. Oregon: Lease payments between related parties are allowed at the lesser of the payments per contract and the owner's cost of the lease.
49. Oregon: A home receives payment up to \$1.09 per patient day for the amount its allowable indirect expenses are less than the indirect ceiling.
50. Oregon: Annualized rate of 10% on average owner's equity.
51. Pennsylvania: Reimbursement for lease payments may not exceed the actual costs of ownership.
52. Pennsylvania: Costs less than ceiling up to a maximum. Proprietary - SNF \$3.39, ICF \$2.79; Nonprofit - SNF \$2.39, ICF \$1.97;  $8\frac{1}{2}\%$  of statewide average cost projection, 6% of nonprofits.
53. Rhode Island: Not to exceed costs of actual ownership, i.e. interest + depreciation - R.E. taxes, etc.
54. Rhode Island: Limited to leasehold improvements depreciable over the useful life of the asset.
55. Rhode Island: All providers, proprietary and nonprofit are allowed a \$0.60 per patient day participation incentive provided that the rate assigned remains below the aggregate maximum.
56. South Carolina: No more than allowed if facility were to be sold.
57. South Carolina: Half the difference to maximum of 7.5% of standard.



58. Tennessee: Lower of owner's costs or lease payment.
59. Tennessee: Up to \$1.50 per day.
60. Tennessee: The return on equity and cost containment incentive may not exceed \$1.60 ppd.
61. Utah: The cost of the owner is allowable cost and the costs recognized in the March 1981 rate.
62. Utah: ROE is set on the 3/27/81 rates and does not change as a result of new calculations.
63. Washington: Lease expense is tested against a lid computed from a regression comparing all contractors' depreciation and interest expense to facility age and contractor types.
64. West Virginia: Incentives on certain cost centers; 50% of cost savings if a facility has no survey deficiencies in that cost center.
65. West Virginia: Return is based on percentage of the Standard Appraised Value capitalized at the Medicare rate of return.
66. Wisconsin: Ceiling amount based on year of facility construction and year taken over by an operator. Ceiling is standard estimated ownership cost; new leased structures limited to owner's cost.
67. Wisconsin: No, with select exceptions for remodeling and property taxes.
68. Wisconsin: Percentage of difference between "targeted cost" and facility's actual cost.
69. Wisconsin: 1.25 x 3 years composite average cost of Hospital Insurance Trust Fund.



C. NURSING HOME REIMBURSEMENT  
CHART 5  
INDEXING INFLATION

	Index Used to Inflate Rates	Index Used to Inflate Rates			Index Sets Limit for Allowable Costs	Pass Throughs on Certain Costs	Index Applied Uniformly Across Homes	Index Weighted by Each Home	Index Weighted From Groups of Homes	Adjustments are Made in the Index	Adjustments are Made	
		Industry Wide Rate	Rates for Groups of Homes	Rates for Individual Homes							During the Year	At the Rate Year's End
AL	Yes	Yes				Yes(1)	Yes			Yes	Yes(2)	AL
AK												AK
AZ	Yes(4)	Yes					Yes			Yes	Yes	AZ
AR												AR
CA	Yes			Yes			Yes			Yes	Yes(5)	CA
CO	Yes	Yes			Yes(6)	Yes(7)	Yes			Yes		CO
CT	Yes				Yes		Yes			Yes		CT
DE	Yes		Yes(8)	Yes			Yes					DE
DC	Yes					Yes(10)	Yes			Yes	Yes	DC
FL	Yes	Yes			Yes(9)		Yes			Yes		FL
GA					Yes(11)		Yes			Yes		GA
HI	Yes		Yes		Yes	Yes(12)	Yes	Yes				HI
ID	Yes				Yes	Yes(14)	Yes	Yes			Yes	ID
IL	Yes				Yes		Yes	Yes		Yes	Yes	IL
IN	Yes				Yes	Yes(16)	Yes	Yes		Yes	Yes	IN
IA	Yes	Yes			Yes		Yes	Yes		Yes	Yes	IA
KS	Yes				Yes		Yes	Yes		Yes	Yes	KS
KY	Yes	Yes			Yes	Yes(18)	Yes	Yes		Yes	Yes(15)	KY
LA					Yes(17)							LA
ME	Yes			Yes	Yes(19)	Yes(20)	Yes	Yes		Yes	Yes(21)	ME
MD	(22)				Yes		Yes					MD
MA	Yes	Yes			Yes(23)		Yes	Yes		Yes(24)		MA
MI	Yes						Yes	(25)		(26)		MI
MN					Yes(27)		Yes	Yes				MN
MS	Yes				Yes(28)		Yes	Yes		Yes	Yes	MS
MO												MO
MT							Yes					MT
NE				Yes(29)								NE
NV	Yes					Yes(31)	Yes	Yes		Yes		NV
NH	Yes			Yes			Yes					NH
NJ						Yes(32)	Yes	Yes		Yes	Yes	NJ
NM	Yes	Yes			Yes		Yes					NM
NY	Yes	Yes			Yes	Yes(35)	Yes	Yes			Yes	NY
NC	Yes	Yes(33)										NC
ND	Yes				Yes		Yes					ND
OH	Yes	Yes			Yes(34)		Yes					OH
OK	(36)											OK
OR	Yes	Yes			Yes	Yes(38)	Yes	Yes		Yes	Yes(37)	OR
PA	Yes		Yes				Yes	Yes				PA
RI	Yes			Yes		Yes	Yes	Yes				RI
SC	Yes				(39)		Yes	Yes				SC
SD	Yes			Yes			Yes	Yes				SD
TN	Yes				Yes(43)		Yes	Yes		Yes	Yes(42)	TN
TX	Yes(40)		Yes(41)		Yes		Yes	Yes		Yes		TX
UT	Yes				Yes(44)		Yes					UT
VT	Yes											VT
VA	Yes	Yes					Yes	Yes				VA
WA	Yes				Yes(45)		Yes	Yes				WA
WV	Yes	Yes				Yes(46)	Yes	Yes				WV
WI	Yes(45)					Yes(47)	Yes	Yes				WI
WY	Yes	Yes			Yes							WY

## C. NURSING HOME REIMBURSEMENT

### CHART 5 NOTES INDEXING INFLATION

1. Alabama: Index is not used to limit costs but to inflate for prospective rate purposes. Property costs such as rent, amortization, interest, and depreciation are not inflated but enter rate as is.
2. Alabama: Established each October 1 for the current fiscal year (7-1/6-30). Rates run from July 1 - June 30. Rates are reset during Sept.-Nov. each year, then weighted back to July 1.
3. Alaska: Presently in transition to a prospective payment system. Survey responses reflect interim: 7-1-83 through 6-30-84.
4. Arkansas: The inflation factor will be determined by projecting a 12-month factor based on historical averages of Series A, urban wage workers.
5. Colorado: July 1 and January 1.
6. Connecticut: The implicit price deflator of the GNP is utilized.
7. Connecticut: Plant operation and maintenance, employee benefits and administration (except owner's related party salaries). Since a portion of index is estimated if estimate proves to be incorrect by 5% or +, index adjusted can go down.
8. Delaware: The inflation rate is only given to private homes. It is not given to state-owned institutions.
9. Florida: Data Resources, Inc. skilled market basket components are weighted by Florida cost data.
10. Florida: Property cost and return on equity are passed through uninflated.
11. Hawaii: Routine costs limit includes SNF market basket index used to account for actual and projected cost increases - 75th % of private homes only.
12. Idaho: Property costs including depreciation, interest, taxes, leases, etc.
13. Illinois: Updated by components of the CPI after adjustments for Illinois experience.
14. Illinois: Capital costs such as depreciation, interest and property taxes are not inflated by an index.
15. Kansas: Once at the beginning of the limitation period, which runs from 10/1 to 9/30 of each year.
16. Kansas: When a new rate is determined from the provider's cost report filed within 90 days after the end of their fiscal year.
17. Kentucky: Total allowable costs are inflated.

18. Kentucky: Capital costs are not indexed.
19. Maine: DRI Index.
20. Maine: Capital costs only.
21. Maine: Changes in staffing necessitated by changes in conditions of patients.
22. Massachusetts: Don't use a prospective rate system.
23. Michigan: Used in the calculation of the variable cost 80th percentile which serves as the variable cost limit.
24. Michigan: For industry-wide changes in standards and for significant deviations of industry cost experience from the projected inflation factor.
25. Minnesota: No index. Percentage created by state statute: 6%.
26. Minnesota: Grouped at 60th percentile.
27. Mississippi: Costs per day.
28. Missouri: A combination of a percentage of a home's rate plus a flat amount based upon a negotiated percentage amount.
29. Nebraska: Current under retroactive answers. One to proposed plan to start 8/1/82.
30. New Hampshire: ICF - 75% limit on variable costs arrayed in 3 bed groups (0-49, 50-99, 100+) and also customary charges to the general public.
31. New Hampshire: Capital costs are not capped.
32. New York: Utilities and ancillary costs other than PT, ST, OT and prescription drugs, real estate taxes.
33. North Carolina: Industrywide for ICF and SNF. Separate index for ICF-Mental Retardation.
34. North Dakota: The consumer price index CPI (all items) is applied to costs, excluding salaries and fringes, the CPI used is the one for the month in which the facility's fiscal year ends.
35. Ohio: All but general and administrative remit respectively.
36. Oklahoma: State establishes reimbursement rate through negotiation with the Nursing Home Association. The rate, for the most part, is based on the prior year's rate of payment, adjusted for inflation or any increase in required standards or services.
37. Oregon: During rate usually 7/1 not in '82 because of budget deficit at end of year January 1.

38. Pennsylvania: Example: '82-'83 Ceiling. The known CPI-W indexes up to 12-31-81 were projected forward (using linear regression) to 6-30-83. An estimated inflation index was calculated for each month between 12-31-81 and 6-30-83. Then each facility's reported costs were projected to 3-1-82 and rolled forward to 6-30-82 and then again to 6-30-83.
39. South Carolina: Used CPI, contemplated a state index.
40. Texas: Twelve indices are used to inflate reported cost for prospective rate making.
41. Texas: By level of care.
42. Texas: At each rate cycle
43. Utah: CPI less mortgage interest.
44. Vermont: Determined by Division of Rate Setting, using actual and projected rates of inflation or deflation from CPI. Facility at mean per diem rate after application of the index get amount of index; others get more or less based on whether above or below mean.
45. Wisconsin: Only for calendar year '82. System will revert to referencing actual cost (with appropriate limits in '83). 1982's index was a sliding scale, i.e., expensive homes got smaller increases, low cost homes got bigger increases.
46. Wisconsin: Primarily related to capital, e.g., interest expense is passed through in its entirety.
47. Wyoming: Costs due to change in federal and state law and regulations, e.g., minimum wage increase.



C. NURSING HOME REIMBURSEMENT  
CHART 6  
GROUPING OF FACILITIES

	Cost Limits							Other
	Homes are Grouped for Rates	Limits Placed on Nursing Home Costs	Limits Placed on Total Costs	Limits on Cost Centers	Different Limits for Groups of Homes	Limits on Total Costs Set By:		
						Arbitrary Limit	Percentile Limit	
AL	Yes(1)	Yes	Yes	Yes(2)	Yes(3)	Yes		
AK(4)								
AZ								
AR	Yes	Yes			Yes(5)			
CA	Yes(6)	Yes	Yes	Yes(7)	Yes(7)			
CO	Yes(8)	Yes		Yes(9)	Yes(10)	Yes		
CT	Yes(11)	Yes				Yes		
DE								
DC	Yes(12)	Yes		Yes(13)	Yes			
FL	Yes(14)	Yes		Yes	Yes			
GA	Yes	Yes	Yes	Yes(15)	Yes(16)			Yes(cost. changes)
HI	Yes	Yes		Yes(17)	Yes			
ID	Yes(18)	Yes		Yes(19)	Yes(20)			
IL	Yes	Yes	Yes		Yes(21)			Yes(22)
IN	Yes	Yes		(23)		Yes		
IA	Yes(24)	Yes	Yes	Yes(25)	Yes(26)	Yes		
KS	Yes(27)	Yes(28)	Yes	Yes(29)	Yes(30)	Yes		Yes(115% of median)
KY								
LA	Yes(31)	Yes	Yes					Yes(31)
ME	Yes	Yes	Yes	Yes(32)	Yes			
MD	Yes	Yes	Yes	Yes(33)	Yes(34)			
MA	Yes(35)	Yes	Yes	Yes(36)	Yes(36)	Yes		
MI	Yes	Yes	Yes	Yes(37)		Yes(36)		
MN	Yes	Yes	Yes	Yes(38)		Yes		
MS	Yes	Yes	Yes	Yes(39)		Yes		Yes(125%)
MO	Yes(40)	Yes	Yes					
MT								
NE	Yes	Yes	Yes	Yes(41)	Yes(42)	Yes		Yes(110%)
NV		Yes	Yes	Yes(43)				
NH	Yes(44)	Yes	Yes	Yes(45)				
NJ	Yes	Yes		Yes(46)				Yes
NM	Yes	Yes	Yes	Yes(47)	Yes(48)	Yes		
NY	Yes(49)	Yes	Yes	Yes	(50)	Yes		
NC	Yes	Yes	Yes	Yes(51)		Yes		
ND		Yes	Yes	Yes(52)				
OH		Yes	Yes	Yes(53)	Yes			Yes(54)
OK(55)	Yes	Yes	Yes					
OR		Yes	Yes	Yes(56)		Yes		
PA	Yes(57)	Yes	Yes	Yes(58)				Yes(59)
RI	Yes	Yes	Yes	Yes(60)				Yes(61)
SC	Yes	Yes	Yes	Yes(62)	Yes(63)			
SD	Yes	Yes	Yes	Yes(64)				Yes(65)
TN		Yes	Yes		(66)	Yes		
TX	Yes(67)	Yes	Yes	Yes(68)				
UT								Yes(69)
VT								
WA	Yes(70)	Yes	Yes	Yes(71)	Yes(70)			Yes(72)
WV	Yes	Yes	Yes	Yes(73)				
WI	Yes(74)	Yes	Yes	Yes(75)	Yes			Yes(75)
WY	Yes	Yes	Yes	Yes		Yes		Yes(76)

## C. NURSING HOME REIMBURSEMENT

### CHART 6 NOTES GROUPING OF FACILITIES

1. Alabama: 1) SNF and ICF, Combination Facilities (grouped together) Administrative cost center 60th cap by bed size groupings: 1-50 beds, 51-75 beds, 76-100 beds, 101-150 beds, and 151 beds and up. Overall 60th percentile within facility classification groupings: SNF only, ICF only, combination (ICF-MR facilities are limited by an overall 60th percentile under different reimbursement guidelines.)

2) Administrative 60th% Cap (SNF, ICF, Combination Grouped Together)

	<u>1-50 beds</u>	<u>51-75 beds</u>	<u>76-100 beds</u>	<u>101-150 beds</u>	<u>151 and up</u>
Facilities	35	43	37	59	33
Beds	1490	2699	3270	7062	6169

#### Overall 60th Cap

	<u>ICF only</u>	<u>SNF only</u>	<u>Combination only</u>	<u>ICF/MR</u>
Facilities	18	2	187	5
Beds	1010	86	19,594	1523

2. Alabama: General and administrative capped at 60%.
3. Alabama: Administrative costs capped by bed size; total costs capped by level of care.
4. Alaska: Presently in transition to a prospective payment system. Survey responses reflect interim: 7-1-83 through 6-30-84.
5. Arkansas: Only administrative salaries limited by home size.
6. Colorado: See Regs. 8.441.2.
7. Colorado: See Regs. 8.441.3.
8. Connecticut: By level of care, i.e., SNF, ICF, HFA.
9. Connecticut: As described in IIIC above for laundry, housekeeping, dietary and nursing.
10. Connecticut: Each facility has its own "cap" based on historical costs.
11. Delaware: There are two groupings: private homes and state-owned homes.
12. Florida: Facilities are grouped by geographic location (north/south) and bed size (less than 101 beds/greater than 100 beds).
13. Florida: Direct patient care and operating costs (laundry, housekeeping, administrative salaries, etc.).
14. Georgia: Ch. 1000, page x-3.

15. Hawaii: Per HIM 15-I, Sec. 2500. Limits are placed on inpatient general routine service cost.
16. Hawaii: Caps lower for freestanding SNFs than for hospital based SNFs and non-SMSA SNFs than SMSA SNFs; E4-Routine Costs 112% of group mean.
17. Idaho: Non-property, non-ICF/MR patient care costs.
18. Illinois: Grouped by HSA; for capital rates, there are subgroups according to year or acquisition of the facility.
19. Illinois: The general service costs and administrative costs are limited to a ceiling of the 60th percentile of the group costs. Nursing costs and capital costs also have ceiling limits built into the reimbursement methodology.
20. Illinois: The caps are based upon the costs incurred by the homes in that group, e.g., the support costs are limited to 60th percentile.
21. Indiana: The state is divided into three regions, each with its own compiled average allowable cost wherein the incentives factor for efficient operation is applied.
22. Indiana: Reimbursement of allowable costs is subject to 5 limiters, whichever is lowest: the calculated rate; maximum allowable rate increase; the rate charged to the general public; the rate requested by the provider; the Market Area Limitation = (140% of the average rate).
23. Iowa: Individual items such as administrators' salaries, owner/operator/related party conditions.
24. Kansas: SNC, ICF, and ICF/MR.
25. Kansas: Administration, property, room and board, and health care.
26. Kansas: Limits established for each level of care, i.e., SNF, ICF or ICF/MR.
27. Kentucky: ICF; SNF; ICF/MR; dual-licensed pediatric.
28. Kentucky: Only on newly participating facilities.
29. Kentucky: Nursing, dietary, capital, all other costs, for newly participating facilities.
30. Kentucky: Cap on: ICFs, SNFs, dual-licensed pediatric; no cap on: ICF/MR.
31. Maine: Previous year's costs inflated by the DRI becomes the ceiling.
32. Maryland: Administrative and routine; other patient care costs; nursing; and capital costs.
33. Massachusetts: The cost centers are variable, and nursing costs and costs which are over 1 standard deviation above the mean are not allowed.
34. Massachusetts: The mean costs are different.



- |                       |  |                   |             |
|-----------------------|--|-------------------|-------------|
| 35. <u>Michigan</u> : | Facilities are grouped into four classes:                                    | <u>Facilities</u> | <u>Beds</u> |
| 1.                    | Privately owned proprietary and non-profit nursing homes (Both ICF & SNF)    | 372               | 39,801      |
| 2.                    | County owned medical care facilities and hospital LTC units (Both ICF & SNF) | 64                | 6,417       |
| 3.                    | Privately owned SNF/MR facilities  | 9                 | 1,005       |
| 4.                    | State owned ICF/MR Institutions  | 12                | 4,328       |
36. Michigan: Plant cost limit same for classes 1 to 3 above. Variable cost (total cost less plant cost) limit is different 80th percentile for each class 1 to 3 above. ICF/MRs (4th class above) are paid in accordance with Medicare Principles of Reimbursement.
37. Minnesota: Nursing care, general and administrative, top management compensation, property costs.
38. Mississippi: For facilities with less than the minimum occupancy of 80%.
39. Mississippi: Owner's compensation, home office administrative costs, number and type of vehicles.
40. Missouri: ICF, 154 facilities, 12,945 beds; SNF/ICF, 128 facilities, 14,999 beds; SNF 5 facilities, 178 beds.
41. Nebraska: 14% of variable cost.
42. Nebraska: Overall set at cap. for their group as described in Chart 4, #37.
43. Nevada: Administration and housekeeping.
44. New Hampshire: Administrative services, motor vehicle expenses, 75% on variable costs.
45. New Hampshire: Percentile is calculated for each of 3 bed size groups described below:
- |            |                 |             |
|------------|-----------------|-------------|
| 0-49 beds  | - 18 facilities | - 612 beds  |
| 50-99 beds | - 25 facilities | - 1778 beds |
| 100+ beds  | - 20 facilities | - 3230 beds |
46. New Jersey: Food, non-food general services, administration, legal fees, building square footage and cost per square foot, land area and value of area, nursing utilities, insurance, special patient care services, maintenance, original equipment.
47. New Mexico: Administrator's compensation.
48. New Mexico: Separate limits calculated for ICF, SNF, and ICF/MR.
49. New York: Based on bed size, region and intensity level.
50. New York: Same group ceiling applied by multiplying per diem by patient days.
51. North Carolina: Limits are placed on groups of cost centers. A direct group and indirect group. We limit reimbursement for some items such as the medical director.



52. North Dakota: Administrative costs are limited to 15% of total costs.
53. Ohio: Limits on raw food, dietary support, medical support, nursing and rehabilitation; physician review, general and administrative; cost of ownership; physicians' review – total costs limited by costs charges or Medicare rate.
54. Ohio: Lower of cost or charges and/or Medicare rate are only limits to total rate.
55. Oklahoma: State establishes reimbursement rate through negotiation with the Nursing Home Association. The rate, for the most part, is based on the prior year's rate of payment, adjusted for inflation or any increase in required standards or services.
56. Oregon: Indirect cost centers of administrative salaries, general and administrative expenses and plant and shelter expenses.
57. Pennsylvania: Grouped according to applicable SMSA.
58. Pennsylvania: Nursing costs, administrative and general costs are limited.
59. Pennsylvania: Use the median to set limits to net operating costs as they apply to each SMSA group.
60. Rhode Island: Fixed property 90th percentile. Other property 70th, nursing and dietary 80th, energy 90th, all other 70th.
61. Rhode Island: The sum of the cost centers subject to the maximum in each cost center.
62. South Carolina: Nursing, dietary, housekeeping, laundry and maintenance and administrative.
63. South Carolina: Based on type and size of facility.
64. South Dakota: Direct patient care, direct administration.
65. South Dakota: 110%.
66. Tennessee:  
ICF 30.61 - Methodology is same as outlined in state plan.  
SNF 46.36 - Methodology is same as outlined in state plan.  
ICF/MR - None
67. Texas: By level of care.
68. Texas: Reimbursement rates for 3 levels of care are set at the sum of the 60th percentile per diem projected expenses in patient care, dietary facility and administrative costs areas.
69. Utah: Limits are placed on payment rates rather than cost.
70. Virginia: "Groups" means areas: northern Virginia and remainder of the state.
71. Virginia: Administrators' compensation, directors' fees, medical directors' fees.

72. Virginia: A median plus current escalator (CPI).
73. Washington: Administration (percentile limit) and food (limit set by mean).
74. West Virginia: Groupings are by licensure type and bed range: ICF (0-40, 41-80; 81-120; 121+) and SNF/ICF (0-60; 61-120; 121+).
75. West Virginia: Standard cost areas: adjusted mean; mandated cost areas: percentile; nursing: assessment; property: standard appraised value.
76. Wisconsin: Sliding scale increases within range of 5%-7%. Expensive homes get lower increase, lower cost homes set higher increase.

C. NURSING HOME REIMBURSEMENT  
CHART 7  
COST LIMITS

Cost Limits										
Limits on Cost Center Set By										
Arbitrary Limit		Percentile Limit	Mean	Mean and Percentage of Mean		Other	Costs Exempted From Limits		Case Mix Adjustment	Considering New System
AL		Yes								AL
AK(1)										AK
AZ										AZ
AR										AR
CA							Yes(2)			CA
CO			Yes			Yes	Yes(3)		Yes	CO
CT										CT
DE										DE
DC										DC
FL						Yes	Yes(4)			FL
GA		Yes(5)		Yes		Yes(6)	Yes		(7)	GA
HI							Yes(8)			HI
ID		Yes					Yes(9)			ID
IL		Yes						Yes		IL
IN										IN
IA							(10)			IA
KS		Yes				Yes(11)				KS
KY										KY
LA										LA
ME							Yes(12)			ME
MD						Yes(13)	Yes(14)	Yes(15)	(16)	MD
MA			Yes							MA
MI		Yes				Yes(17)	Yes(18)		Yes	MI
MN		Yes				Yes(19)				MN
MS						Yes(20)				MS
MO										MO
MT										MT
NE		Yes					Yes(21)			NE
NV	Yes						Yes(22)			NV
NH	Yes	Yes					Yes(23)		Yes(24)	NH
NJ						Yes				NJ
NM						Yes				NM
NY						Yes	Yes(25)	Yes		NY
NC						Yes(26)				NC
ND										ND
OH	Yes			Yes(27)		Yes(28)	Yes(29)	Yes		OH
OK(30)										OK
OR		Yes								OR
PA		Yes				Yes(31)	Yes(32)			PA
RI		Yes(33)								RI
SC						Yes(34)	Yes(35)		Yes	SC
SD				Yes(36)			Yes(37)			SD
TN										TN
TX										TX
UT						Yes(38)		Yes(39)		UT
VT		Yes								VT
VA							Yes(40)			VA
WA	Yes	Yes	Yes							WA
WV		Yes	Yes(food)			Yes			Yes(41)	WV
WI		Yes					Yes	Yes		WI
WY										WY

## C. NURSING HOME REIMBURSEMENT

### CHART 7 NOTES COST LIMITS

1. Alaska: Presently in transition to a prospective payment system. Survey responses reflect interim: 7-1-83 through 6-30-84.
2. Arkansas: Majority of cost reimbursed by rate paid to facility for level of care not limited; limits placed on some costs, such as administrative salary.
3. Colorado: See Regs. 8.441.3.
4. Florida: Property costs and return on equity.
5. Georgia: Policies and Procedures Manual, Chapter 1000.
6. Georgia: Insurance and property tax not limited.
7. Georgia: Policies and Procedures Manual, Chapter 1000.
8. Hawaii: Allocated capital-related costs that are part of general inpatient routine service costs are excluded from the routine cost limitation. (Per HIM-15-II Sec. 334.1).
9. Idaho: Property costs.
10. Iowa: Most cost items not limited.
11. Kentucky: Nursing 125% of median, capital 105% of median, dietary 125% of median; all other costs 105% of median.
12. Maine: Fixed or capital costs.
13. Maryland: Median plus a percentage for administrative/routine and other patient care.
14. Maryland: Any cost that is an allowable and reasonable cost is included, but the aggregate costs of a facility are limited to a total of the cost centers.
15. Maryland: See Intermediate Care Facility Services regulations, .070, October 1, 1982.
16. Maryland: Current skilled and intermediate regulations became effective January 1, 1983.
17. Michigan: Plant cost limit on plant costs; see Chart 6, #36.
18. Michigan: Ancillary service cost centers--physical and occupational therapies and speech and audiology.
19. Minnesota: Cost indices--construction cost index used to determine the investment per limitation for allowable depreciation purposes.



20. Mississippi: Maximum number, amount, or percentage of other costs.
21. Nebraska: Under current-fixed costs.
22. Nevada: Employee benefits and health care.
23. New Hampshire: No limit on capital costs.
24. New Hampshire: Considering limiting the capital cost center, specifically depreciation; however, changes are in formative stages and no written discussions or proposed documents are available at this time.
25. New York: Real estate taxes, pass through items.
26. North Carolina: Analysis and comparison using surveys and cost report experience. It is an informal process.
27. Ohio: E4 - 115% mean for dietary, medical supplies, nursing supplies.
28. Ohio: General and administrative expenses mean + 4/5 SD.
29. Ohio: F - utilities, property, taxes, payroll taxes.
30. Oklahoma: State establishes reimbursement rate through negotiation with the Nursing Home Association. The rate, for the most part, is based on the prior year's rate of payment, adjusted for inflation or any increase in required standards or services.
31. Pennsylvania: Variety of percentile and absolute limits by cost center; general and administrative costs are capped at 13% of total operational costs with some exception allowed.
32. Pennsylvania: Any cost items not specifically limited are still limited by the net operating ceiling.
33. Rhode Island: Fixed property 90th percentile. Other property 70th, nursing and dietary 80th, energy 90th, all others 70th.
34. South Carolina: Nursing, dieting, housekeeping, laundry and maintenance and administrative. E5 - lower of mean or actual costs.
35. South Carolina: Utilities, cost of capital, taxes and insurance and medical supplies.
36. South Dakota: 110% of statewide class: direct patient care, dietary, laundry, administrative, net per diem.
37. Tennessee: Only limit is owner's compensation, return on equity, containment incentive and the inflation factor.
38. Utah: Payment limited by flat rate.
39. Utah: Payment rate by level of care: SNF, ICF, IMR-1, IMR-2, and IMR-3.
40. Virginia: Drugs and plant costs for nursing homes; Education costs for hospitals.

41. West Virginia: Proposing to change ceiling for standard cost centers; proposing to eliminate licensure type as a criterion in categorizing operating costs (presently a higher than warranted cost base for SNF/ICF facilities).

## I. SERVICES

### 1. GENERAL

#### A. Amount, Duration and Scope

AZ \*A 10/82 (+) Arizona, which has had no Medicaid program in the past, implemented in October 1982 the Arizona Health Care Cost Containment System (AHCCCS). Mandated by its legislature through enactment of S.B. 1001, AHCCCS is a limited Medicaid approach. Arizona has received approval of a number of 1115 waivers in order to implement the program, which will run for three years as a demonstration project. Federal funds cover approximately 59 percent of program costs, with the state and counties paying the remainder. Most, but not all, mandatory services are provided. Not covered are: nursing home services and home health care (which the counties now provide), family planning, nurse-midwife services, and some EPSDT services. The program operates on a prepaid, capitated basis, and providers are selected through competitive bidding. AHCCCS is available to AFDC and SSI recipients and to single individuals with incomes below \$3,200 a year.

CA \*A 1/83 (-) The state-funded Medically Indigent Adult (MIA) eligibility category was eliminated, effective January 1, 1983. Exempted are pregnant women and residents of SNFs/ICFs. County governments have assumed responsibility for approximately 270,000 persons statewide under the auspices of Welfare and Institutions Code 17000. Counties are empowered to determine the services provided, and by whom (and where) they are provided.

The State will provide ongoing block grant funding to counties to meet the costs of providing services to this new population. Funding for the last six months of FY 1982-83 is set at 70 percent of the amount that would have been expended under Medi-Cal if these persons' eligibility had continued. Funding will be allocated to counties based on historical expenditures for MIAs from each county. Counties are required to submit plans to the Department of Health Service detailing how services are to be provided, and counties are prohibited from reducing county spending

for inpatient/outpatient and public health services.

Counties with populations under 300,000 (of which there are 43) are provided the option of contracting back to the Department of Health Services for the provision and payment of care for MIA patients.

\* CA \*C /83 (-) California is considering the elimination or restricted use of optional services.

CA \*A 9/82 (-) California has tightened its definition of medical necessity. Medical, surgical and other services are considered medically necessary when they are needed to protect life or prevent significant disability. Those elective services which can be eliminated without seriously endangering life or causing a significant disability will no longer be approved. This provision is currently being challenged in state court.

CA \*X 7/82 (-) California proposed to suspend for one year coverage of certain benefits for its Medically Indigent Adult category, which is totally state-funded. The outpatient services which were considered for suspension included:

- chiropractic
- podiatry
- optometry/eye appliances and glasses
- psychology
- non-emergency medical transportation
- acupuncture
- physical therapy
- speech therapy
- occupational therapy
- audiology/hearing aids

This proposal has been dropped.

CA \*A 6/82 (-) (AB 1700) The California legislature enacted a law that requires legislative review of any benefit changes having fiscal impact of greater than \$500,000.

\* KS \*A 4/83 (-) Kansas ceased state-only funded medical coverage of General Assistance recipients 18 years and older under the Medicaid Program. These individuals became eligible for the new MediKan Program, which provides medical care in acute situations and during catastrophic illnesses. Generally, there are fewer covered



services, greater limitations and higher cost-sharing than in the Medicaid program.

- KY \*X 1/82 (-) The Kentucky legislature reported that a bill was introduced to require that specific dollar amounts for each optional service be budgeted and appropriated (S129). This proposal has been dropped.
- ME \*X 2/83 (-) The State of Maine proposed the elimination of coverage of all optional services with the exception of ICF and ICF/MR services. Those services which would have been dropped are: ambulance, chiropractic, dental (for individuals 21 and older), mental health clinic, eyeglasses (for individuals 21 and older), independent physical therapist services, podiatric, pharmacy, psychological, speech and hearing services (for individuals 21 and older), and prosthetic devices. However, this proposal was withdrawn.
- \* MD \*A 1/83 (-) Maryland ceased coverage of services and procedures which are investigative or experimental.
- \* MI \*X /83 (-) Michigan considered the elimination of optional services; however, this idea was dropped.
- MS \*A 7/82 (-) The Mississippi legislature enacted a law authorizing the Medicaid Commission to eliminate optional services and requiring that it do so for those services for which federal funding is eliminated.
- \* NE \*C /83 (-) Nebraska is considering the elimination of certain optional services.
- NM \*A 6/82 (-) New Mexico limited out-of-state services to those mandated by federal regulations, and defined "out-of-state providers" as those located more than 10 miles from New Mexico.
- \* OH \*A 7/83 (-) (H 291) The Ohio legislature enacted a law which required that Medicaid mental health services be provided by Community Mental Health facilities.
- \* OR \*A 1/84 (-) Oregon signed a contract to buy into Medicare Part B coverage for dually entitled recipients.

OR \*A 12/82 (-) The Oregon legislature passed a law which expands the definition of Medical Assistance to include payments for insurance and other contractual arrangements.

UT \*P 1/82 (-) The Utah state legislature has introduced a bill which provides that the state is not required to pay for Medicaid services when funds are unavailable or have not been appropriated (HB78).

#### B. Utilization Controls

AK \*A 10/82 (-) Alaska established a surveillance and utilization review system (SURS) unit.

\* AZ \*A /83 (+) (SB 1279) The Arizona legislature enacted a law which abolished co-premium requirements for state-defined medically needy recipients.

\* CA \*P 4/83 (-) California is considering modifying its copayment levels to the maximums permitted under TEFRA.

\* CA \*A /83 ( ) (AB 1757) The California legislature clarified copayment law to require that providers cannot deny services because of recipient inability to pay the copayment and that copayments cannot be required before services are received.

\* CA \*A 5/82 (-) Legislation was passed in California requiring the imposition of copayment for categorically and medically needy Medi-Cal recipients on a selected basis. A copayment of \$5.00, with exceptions for children under 12 and women receiving prenatal care, is required for non-emergency care received in an emergency room. A copayment of \$1.00 is required for drug prescriptions, with the following exceptions:

- children under 12;
- aged persons;
- persons with chronic conditions requiring multiple prescriptions; and
- persons who are inpatients in a health facility.

A copayment of \$1.00 is required for most outpatient services, again with exceptions for children under 12, women receiving prenatal services, children in foster care and persons in a hospital or nursing home.

Copayments are collected by or obligated to the provider at the time the service is rendered. At the provider's option, the copayment amount may be waived. Any copayment collected is in addition to the usual program reimbursement.

The program began May 1982 after California received an 1115 waiver.

- CA \*A 2/82 (+) California expanded the extent of services minors may receive under Medi-Cal without parental consent or liability to include mental health and counseling services for minors determined mature enough to participate in the treatment and who would harm either themselves or others without treatment. These services are state-only funded (not federally funded).
- CA \*A 1/82 (-) California's Beneficiary Utilization Review Unit expanded its activities to include review of beneficiaries who are suspected of overutilizing or abusing medical office visits. Recipients found to be overutilizing or abusing will be placed on "restriction" for 24 months, and prior authorization will be required for affected services.
- \* CO \*X /83 (-) (SB 95) The Colorado legislature reported introduction of a bill to allow imposition of copayments. The bill passed, but was vetoed by the Governor. The bill was returned to the legislature and did not receive enough votes to override the veto.
- CT \*X /82 (-) The Connecticut legislature reported that bills were introduced to establish copayments on various types of services. One bill (H9069X) would have set these copays on medically needy optional services. Another bill (H5221) would have required the Department of Income Maintenance to establish copays on all services. These proposals did not pass.
- \* DC \*P /83 (-) The District of Columbia is proposing implementation of a lock-in program.
- FL \*X 4/83 (-) It was proposed by the Governor of Florida in his budget recommendations that a drug copayment be imposed on Medicaid recipients. However, since Florida's 1982 legislative proviso language prohibited a copayment for drugs, the proposal was dropped.



GA	*A	11/82 (+)	Georgia ceased imposition of copayments. Previously, it charged copayments on all optional services.
*	HI	*X /83 (-)	Hawaii was considering a proposal to impose copayments on a number of goods and services, both optional and mandatory. However, this proposal was dropped.
	HI	*X 1/82 (-)	(SB 2928-82) The Hawaii legislature reported the introduction of a bill that would require public assistance recipients to pay 10% of the first \$200 of medical costs incurred each month. This proposal was dropped.
	IL	*X /82 (-)	The State of Illinois proposed implementing \$1.00 copayments on all drug, dental, optometric, podiatric, and chiropractic services provided to both categorically-related and medically needy recipients.
			Federal 1115 waivers were requested to: a) allow imposition of copayments on services provided to EPSDT recipients; b) exclude long term care patients from the copayment requirement; and c) exceed the federal maximum allowable flat copayment rate for drugs.
			The savings in state funds anticipated from the imposition of these copayments was estimated to be \$20 million for the fiscal year beginning July 1, 1982.
			An earlier proposal had also included copayments on hospital, clinic and physician services. Both proposals have been dropped.
*	IA	*A 5/83 (-)	(SF 541) The Iowa legislature enacted a law which authorized placing restrictions on recipient freedom-of-choice to control overutilization of services.
	IA	*A 4/82 (-)	Iowa Medicaid received a mandate from the legislature to review prior authorization requirements.
*	KS	*A 11/83 ( )	Kansas automated its lock-in program. In conjunction with the automation, effective November 1983, lock-in recipients were issued separate lock-in ID cards which specify the recipient's lock-in provider. The lock-in recipients will also be required, as before, to present the regular Medicaid ID card (which identifies the recipient as being on lock-in



but does not give the provider's name) in order to receive Medicaid services.

- \* KS \*A 12/82 (-) Kansas extended its copayment requirements to EPSDT recipients between 18 and 20 years of age. Previously, all EPSDT recipients were exempted, but the exception has been shifted to all recipients under age 18.
- LA \*X 1/83 (-) Louisiana proposed to impose copayments as follows: \$1 per service for physician visits, mental health substance abuse treatment, home health services, laboratory and x-ray services, rehabilitation services, and chiropractic services; \$1 per prescription for drugs; \$2 per service for non-emergency transportation; and \$3 per service for adult dental care. However, this proposal was dropped.
- \* ME \*A 5/83 (-) (HB 823) The Maine legislature enacted a law which amended copay requirements to conform with TEFRA. In addition to the exemptions required under TEFRA, Maine exempts services to persons under age 21, HMO recipients, and all services to pregnant women including those provided during the post-partum phase of maternity care.
- ME \*A 1/82 ( ) (H 2384) The Maine legislature enacted a bill which mandated a study of the potential impact of a proposed \$2 copayment on most optional services. The report concluded that new TEFRA 1982 copayment restrictions would require high administrative costs that would offset any savings resulting from an expanded copayment policy.
- \* MA \*P 12/82 ( ) The Massachusetts legislature has reported that a bill has been introduced to extend to health care professionals immunity from civil liability arising out of utilization review activities. The present statute only covers medical personnel.
- \* MN \*A 6/83 (-) (SF 1234) The Minnesota legislature enacted a law which established a new utilization review program using both pre-payment and post-payment review. The program will focus on unnecessary utilization, excess payments, unnecessary hospital admissions and lengths of stay, and underutilization of services in pre-paid plans, nursing homes, or services reimbursed at a fixed rate.

*	MO	*P	/83 (-)	Missouri is developing an automated prior authorization system.
	MO	*A	12/82 (-)	Missouri implemented a state utilization review program to replace utilization review as performed by the Professional Standards Review Organizations (PSRO's).
	MO	*A	2/82 (-)	The Missouri legislature enacted a law to expand its lock-in program (which restricts recipients who over-utilize services to one provider) from pharmacy services to all services.
*	NE	*X	/83 (-)	Nebraska considered the imposition of copayments on mandatory services, but has rejected them for the present. However, their imposition could be reconsidered in the future.
	NJ	*C	/82 (-)	The Governor of New Jersey proposed in his budget that fixed-rate copayments be required for selected optional services, with an exemption for institutionalized recipients.
*	NM	*A	1/84 (-)	New Mexico expanded its recipient lock-in program and initiated a provider lock-out program.
*	OH	*A	/83 (-)	(HB 291) The Ohio legislature enacted a law which mandates a pharmacy lock-in for recipients who overutilize services, and a phased-in expansion of the lock-in to other service providers.
*	OH	*X	/83 (-)	(HB 100) The Ohio legislature enacted a law which mandated the imposition of copayments to the maximum extent allowed by federal law. However, the law as written conflicted with federal requirements and could not be implemented.
	OH	*X	10/82 (-)	Ohio implemented a copayment on most optional services on October 1, 1982. Mandated by H.B. 694, the new copayments were as follows:
				Chiropractic -- \$1.00 per date of service;
				Dental -- \$0.50 per date of service;
				Durable Medical Equipment, Orthoses, Prostheses, and Medical Supplies (except family planning supplies) -- \$0.50 per supply code;

Pharmacy (except prescriptions for oral contraceptives) -- \$0.50 per prescription or refill for each drug prescribed;

Physical Therapy -- \$0.50 per date of service;

Podiatry -- \$1.00 per date of service;

Psychology -- \$1.00 per date of service;

Speech and Audiology Services -- \$1.00 per date of service;

Vision Care -- \$1.50 per contact lens (\$3 per pair);

-- \$0.50 per eyeglass lens (\$1 per pair);

-- \$1.00 per eyeglass frames;

-- \$0.50 per eyeglass repair.

Recipients paid only one copayment per date of service per category of service per provider. That is, even if more than one procedure in that category of service was performed on that date by one provider, they paid only one copayment.

Copayments were not charged on outpatient hospital services nor on services provided by an M.D. or a D.O. if a recipient was covered by both Medicare and Medicaid, he did not pay these copayments on services subject to the Medicare payment.

For emergency care, the state deducted the copayment amount from the claims payment; however, the provider could not refuse to provide emergency service to a recipient who did not have the copayment amount available at the time of service.

On October 19, 1982, the copayment program was rescinded due to changes in state administration and federal law.

\* OK \*X /83 (-) (HB 1398) The Oklahoma legislature reports introduction of a bill to impose copayments on certain services equal to ten percent of the total cost of those services. This proposal did not pass.

- \* OR \*A 7/82 (-) Oregon established a provider lock-out program. Practitioners found to be abusing the program will be suspended.
- \* PA \*P /83 (-) Pennsylvania is proposing the imposition of copayments on some or all services at the maximum levels allowed by federal regulations. This is targetted for May 1984. This initiative was recommended by the Governors' Health Care Cost Containment Task Force.
- \* SC \*A 6/83 (+) South Carolina added to its list of exceptions to the drug copayment requirement in order to meet federal guidelines. Additional exemptions include recipients in long term care facilities, recipients under 21 years of age and those receiving prescriptions related to pregnancy.
- VA \*A 7/82 (-) Virginia instituted the maximum allowable copayments for all services provided to medically needy recipients. (This includes copayments for drugs and transportation on a sliding scale).
- \* WI \*A 7/83 (-) (SB 83) The Wisconsin legislature passed legislation to alter the state's copayment requirements to conform with TEFRA provisions.
- \* WI \*C /83 (-) Wisconsin is considering a provider lock-out program.

### C. Reimbursement

- CA \*A 9/82 (-) With few exceptions, Medi-Cal reimbursement to providers has been reduced by ten percent. Specific reductions are outlined below.

Area of Reduction	Estimated Savings	
	Total	General Fund
• Physician and Hospital Outpatient Services	\$ 61.4	\$ 34.2
• Hearing Aids	0.9	0.4
• Acupuncture Services	0.3	0.2
• Portable X-ray Services	0.3	0.2
• Chiropractic Services	0.1	0.1
• Psychology Services	0.8	0.5
• Podiatry Services	0.8	0.4
• Drug Dispensing Fee	2.1	1.0
• Laboratory and Pathology Fees	16.7	9.3
TOTAL SAVINGS	\$ 83.4	\$ 46.3



CA \*X 1/82 (-) (AB7X) The California legislature reports introduction of a bill to reduce provider rates by 2%. This proposal was dropped.

CT \*A 2/82 (-) (S 486) The Connecticut legislature enacted a law that revised uniform fee schedules to reflect the amount appropriated for services. This law applies to practitioners of the healing arts and associated services and to vendors of sickroom supplies.

DE \*A 9/82 (+) Delaware implemented a 5.5% increase in reimbursement for most providers (excluding labs, hospitals, outpatient clinics and other cost-reimbursed or fee-for-service providers) retroactively to October 1, 1981. It now pays these providers 105.5 percent of the 75th percentile of FY 1980 charges.

FL \*X 7/82 (-) Florida has proposed to modify its policy regarding Medicare Part B crossover payments. It would:

- Limit Medicaid reimbursement on Medicare Part B crossover claims to procedure codes identified as Medicaid-covered items and services;
- Limit Medicaid payment for Part B deductibles and coinsurance to the Medicaid maximum allowable fees for the items or services;
- Restrict Medicaid reimbursement on crossover claims to those provider types eligible for enrollment as Medicaid providers; and
- Apply Medicaid caps to crossover claims.

This proposal has been dropped.

\* HI \*A 9/83 (-) Hawaii imposed an overall ten percent reduction in fees to non-institutional providers. Adjustments were made to the usual, customary and reasonable percentile limits. The percentage reduction in the individual practitioners' fees varied according to a formula which imposed greater reductions on those providers who have a higher fee profile.

ID	*X	/83 (-)	Idaho proposed to discontinue paying the Medicare buy-in for non-cash assistance Medicaid recipients. However, this proposal was dropped.
ID	*X	/83 (-)	Idaho proposed to eliminate payment of Medicare Part A coinsurance and deductibles. However, this proposal was dropped.
ID	*A	9/82 (-)	Idaho imposed a nine percent reduction in fees for most non-institutional providers.
*	IL	*X /83 (+)	From March 1983 through June 30, 1983, Illinois reduced all non-group care rates by 7 1/2 percent. The reduction was rescinded after legislative passage of a tax package. A previous court order precluded the rate reduction for nursing homes.
*	IA	*A 7/83 (-)	Iowa lifted the previously imposed 2.5% reduction in reimbursement for those products which are reimbursed at the acquisition cost.
*	IA	*A 7/83 (-)	Iowa limited annual increases in reimbursement to 6% for all non-institutional providers.
*	IA	*A 5/83 (-)	(HF 641) The Iowa legislature enacted a law which reduced payments to providers by 2.5 percent, except for hospital, physician, nursing home, transportation, and supply services.
	IA	*A 4/82 (-)	Iowa imposed a 2.5% reduction for all reimbursement to Medicaid providers except hospitals, intermediate care facilities, intermediate care facilities for the mentally retarded, mental health institutions, drug ingredient costs, and non-ambulance medical transportation reimbursed directly to the recipient.
	KS	*A 5/82 (-)	The state of Kansas began determining reimbursement on a fee-for-service basis for all non-institutional services, with the exception of pharmacy. Fees are on an established base rate related to billed charges or cost report data. The range of charges provided the base for computations of range maximums. Medicare is no longer the base.
*	LA	*P /83 (-)	Louisiana proposes to eliminate the inflation factor in rates paid to all providers.

ME	*X	2/83 (-)	Maine proposed to implement an across-the-board 10% reduction in reimbursement rates for all mandatory services. However, this proposal was dropped.
ME	*A	1/82 (-)	The Maine legislature passed a law requiring an annual review of all provider fee schedules. This review must be presented both to the appropriate legislative committees and to the Governor's office prior to his submission of a budget to the legislature.
MA	*P	8/82 (-)	The Massachusetts Department of Public Welfare is proposing limitations on payment of Medicare Part A coinsurance and deductibles.
*	MI	*A	7/83 (-) (HB 4558) Michigan's Appropriations Act contains a provision that allows reduction or suspension of payments to institutional providers who are cost settled and who do not submit cost reports within 90 days of the end of their fiscal year.
*	MI	*A	7/83 (-) (HB 4558) Michigan's Appropriations Act contains a provision that requires the implementation of uniform statewide reimbursement ceilings for practitioners, to the extent possible under federal law and regulation. Also, when Medicare reimbursement ceilings are de-regionalized, reimbursement ceilings in the highest Medicaid payment area shall not be increased until increases in the other Medicaid payment areas result in uniform statewide reimbursement ceilings.
*	MN	*A	6/83 (-) (SF 1234) The Minnesota legislature enacted a law which placed a limit of 5 percent on rate increases to all vendors except nursing homes and boarding homes. It also exempts the estimated acquisition cost (EAC) of prescription drug ingredients.
*	MN	*A	6/83 (-) (SF 1234) The Minnesota legislature enacted a law which extended for the next biennium the current reimbursement method that limits payment to the 50th percentile of usual and customary fees based on 1979 billings. This limit applies to physicians, dental care, vision care, podiatrists, chiropractors, physical therapy, occupational therapy, speech pathologists, audiologists, mental health centers, psychologists, public health clinics, and independent lab and x-ray services.



*	MN	*A	/83 (-)	Minnesota froze its practitioner rates for its General Assistance Medical Care Program (GAMP, a state-only funded program) to the 1978 profile levels.
*	MN	*A	/83 (-)	(H 742) Minnesota extended a limit of 8% on rate increases to providers, with the exception of nursing homes, until June 30, 1985.
*	MN	*A	/83 (-)	Minnesota extended for two years its freeze on practitioners' rates. Rates will remain at the July 1, 1979 profile levels until June 30, 1985.
*	MN	*A	/83 (-)	(HF XXX) The Minnesota legislature enacted a law which reduced reimbursement rates for all providers by 4% for the period from January 1 to June 30, 1983. Additionally, SF 253 was passed, which exempted HMOs from the reduction.
*	MN	*A	/82 (-)	Minnesota froze, for all practitioners, the reimbursement rates to the July 1, 1979 profile levels. This covered 1982-1983.
*	NE	*A	7/83 (-)	(LB 618) The Nebraska legislature enacted a law which continues, for FY 1984, a limitation of 3.75 percent on reimbursement increases for all providers.
*	NE	*A	6/83 (-)	Nebraska established a new upper limit for payment of joint Medicare/Medicaid services not to exceed the Medicare maximum.
	NE	*A	4/82 (-)	(L 942) The Nebraska legislature enacted a law which limits reimbursement increases to 3.75 percent for all providers for FY 1983.
	NE	*A	4/82 (-)	The Nebraska legislature enacted legislation which provides for a pro rata reduction, at the discretion of the Director of the Department of Public Welfare, of allowable costs for most optional services provided under Medicaid if Medicaid funds are expended at a rate which, if projected, would exceed available funds for the fiscal year.
*	NV	*A	7/83 (-)	Nevada did not grant any increase in reimbursement rates for individual practitioners for FY 1984.
*	NC	*A	7/83 (-)	(SB 23) The North Carolina legislature enacted a law which continued a 7 percent limit on payment increases for home health services, clinic services, ambulance services, EPSDT



screens, hearing aid dispensing fees, rural health clinics, family planning, independent lab and x-ray services, ambulatory surgical centers, and mental health clinics.

- NC \*A 7/82 (+) North Carolina's December 1982 freeze on provider reimbursement levels was lifted, but increase for all services not covered by a special reimbursement plan was limited to 7%.
- \* OR \*A 10/83 (+) The Oregon legislature approved a four percent CPI increase in rates for all providers.
- \* OR \*A 1/83 (+) Oregon granted a five percent CPI increase in practitioners' fees.
- OR \*A 10/82 (-) Oregon delayed the planned 5% CPI increase in practitioners' fees from October 1982 to January 1, 1983.
- OR \*A 7/82 (-) Oregon delayed, for all practitioners, the annual increase in the maximum allowable fees from July (the usual date of the increase) to October, 1982. The state also reduced the increase in rates from the proposed 7% to 5%.
- RI \*X 2/82 (-) (S 7295) The Rhode Island legislature reported introduction of a bill to limit provider fee-for-service increases to 5%. The bill was not enacted.
- SC \*A 7/82 (-) South Carolina continued its freeze on reimbursement levels for non-institutional services.
- SC \*A 7/82 (-) South Carolina adopted fee schedules for all non-institutional services for which fee schedules are not already in place. Earlier, in February 1982, fee schedules were adopted for dental care, vision care and durable medical equipment.
- \* TN \*P 10/83 ( ) For a number of services and goods, including physician and dentist services, ambulance services, and supplies; Tennessee is proposing to upgrade its reimbursement rates (based on usual and customary charges), by changing its base year from CY1980 to CY1982. In 1982 the rates were not upgraded due to technical problems; in lieu of upgrading, the state raised its rates from 90 percent to 95 percent of reasonable charges. Therefore, when the rates are upgraded, it is anticipated that the percentage will be lowered.

- \*    TN    \*P       /83 ( )    (SB 123) The Tennessee legislature reports the introduction of a bill to require that all providers receive the same proportion of usual and customary fees, regardless of their profession.
  
- WA    \*A       7/83 ( )    Washington has implemented vendor rate increases of approximately 2.5% for all fee schedule services, and plans to implement an increase of 3.0% in July of 1984.
  
- \*    WI    \*A       7/83 (-)    Wisconsin limited its average reimbursement rate increases to three percent.
  
- WI    \*A       /83 (-)    The Wisconsin legislature enacted a law which imposes a 90-day delay on all reimbursement rate increases and on any modifications in rate calculation methodologies which were scheduled for implementation during the state fiscal year beginning July 1, 1982 and ending June 30, 1983. Due to subsequent litigation which the state lost, the 90-day delay on rate increases was not allowed for hospitals and nursing homes.

## ACUTE CARE SERVICES

### 2. Inpatient Hospital Services

#### A. Amount, Duration and Scope

- \* AL \*A 7/83 (-) Alabama reduced coverage of inpatient hospital days for all Medicaid recipients from 15 to 12 days per calendar year.
- \* AL \*A 4/83 (-) Alabama reduced from 15 to 12 days per calendar year the total number of inpatient hospital days for those 65 and over in a TB institution.
- \* AL \*A 10/82 (-) Alabama reduced coverage of inpatient hospital days for individuals under 21 from 30 to 15 days, with a maximum of five additional days when authorized by the PSRO as medically necessary. This limitation is the same as that for individuals 21 and over.
- \* AL \*A 7/82 (-) Alabama eliminated coverage of unlimited inpatient hospital days for individuals under 21. As of July 1982, these recipients will be subject to a limitation of 30 days per calendar year.
- \* AK \*P /83 (-) Alaska is proposing to limit inpatient hospital days to the 75th percentile of the average length of stay as indicated in the Professional Activities Study (PAS) for the Western States. Days exceeding this ceiling would need prior authorization.
- AR \*A 3/82 (+) Arkansas modified its inpatient hospital coverage limitation. The limitation, which is based on the average length of stay by diagnosis as determined by the Professional Activities Study (PAS) data for the Southern Region of the U.S., was changed from the 50th to the 75th percentile.
- \* CA \*A /83 (+) (SB 72) The California legislature specifies that liver transplants are not experimental services and requires Medi-Cal to pay for donor and recipient surgery performed at an approved facility.
- CA \*A 9/82 (-) California has tightened its definition of medical necessity. Medical, surgical and other services are considered medically necessary when they are needed to protect life or prevent

significant disability. Those elective services which can be eliminated without seriously endangering life or causing a significant disability will no longer be approved. This provision is currently being challenged in state court.

- \* CO \*A 3/83 (-) Colorado imposed a temporary moratorium on non-emergency surgery. From March 1 through June 30, 1983, surgery was not covered unless the physician certified that it was necessary to the well-being of the patient, and that the condition to be treated was of a life-endangering or deteriorating nature. The moratorium was lifted July 1, 1983.
- CT \*P 10/83 (-) The State of Connecticut is proposing to limit weekend admissions to medically necessary stays.
- \* CT \*P 10/83 (-) The Connecticut Medicaid Agency is proposing to limit pre-operative hospital stays to one day unless otherwise certified by a physician.
- CT \*A 10/82 (-) The State of Connecticut has implemented legislation placing a limit of one day on certain selected pre-operative hospital stays. These include stays related to the following procedures: tonsillectomy, adenoidectomy, hysterectomy, hemorrhoidectomy, cholecystectomy, meniscectomy, submucous resection/rhinoplasty, excision of varicose veins, disc surgery spinal fusion, and dilation and curettage.
- CT \*X 2/82 (-) (H 5235) The Connecticut legislature reports the introduction of a bill to: 1) prohibit non-emergency weekend admissions; 2) limit pre-operative hospital stays to 1 day; 3) require preadmission lab tests; and 4) require that the primary surgeon authorize assistant surgeon charges. This proposal was dropped.
- CT \*X /82 (+) The State of Connecticut was considering imposing a 21-day limit on psychiatric inpatient stays for adults in general hospitals. This proposal has been dropped.
- \* FL \*C /83 (-) Florida is considering a limitation in its coverage of inpatient hospital days which would be related to Florida-specific data based on diagnoses.
- FL \*X /82 (+) Florida was considering removal of a 45-day ceiling on inpatient hospital care. This would



have been a demonstration in two counties in Florida. However, this proposal has been dropped. (Contact: Mike Morton 904/488-9990)

- \* GA \*A 1/83 (+) Georgia dropped its 25-per-year limitation on covered inpatient hospital days (i.e., pre-set allowable days).
- GA \*A 4/82 (+) Georgia raised its limitation on inpatient hospital coverage from 20 to 25 days per fiscal year. In addition, days beyond this limit will be paid if they are medically necessary and are prior authorized.
- ID \*A 9/82 (-) Idaho reduced hospital coverage from 40 days per admission to 40 days per year.
- \* IL \*A 1/82 (-) Illinois began limiting payment for pre-operative inpatient hospital days to the day immediately preceding surgery, unless the attending physician has documented the medical necessity of an additional day or days.
- \* IL \*A 1/82 (-) Under its inpatient hospital coverage, Illinois ceased covering ancillary services and routine tests unless there is a patient-specific written order for the test from the attending physician or responsible practitioner.
- IA \*A 7/82 (-) Iowa mandated that certain surgical procedures be performed on an outpatient basis, and prohibited payment for inpatient care in conjunction with those procedures when they are performed on an inpatient basis. One hundred eighty procedures are identified as falling into this category. Exceptions may be made for medical necessity, but must be pre-authorized.
- IA \*P 7/82 (-) Iowa has proposed removing coverage of intestinal or gastric bypass surgery for treatment of obesity.
- IA \*A 4/82 (-) Iowa limited coverage for inpatient hospital care to the 50th percentile of length of stay as indicated for recipient's diagnosis in Length of Stay in PAS Hospitals. Provision will be made for payment of longer stays in exceptional cases.
- \* KS \*A 9/83 (-) Kansas limited coverage of the mother's stay for Medicaid normal deliveries to two hospital days. This limitation does not apply to the newborn.

*	KS	*A	5/83 (-)	Kansas adopted a policy that no leave days will be covered for any reason or diagnosis when a recipient is away from an inpatient general hospital.
	KS	*X	5/82 (-)	The state of Kansas considered a 50th percentile limitation on hospital lengths of stay. However, this proposal has been dropped.
	KS	*A	1/82 (+)	Kansas began covering intra-ocular lens implants, with prior authorization, for cataract patients 65 years of age and older.
	KY	*A	9/82 (-)	Coverage under the Kentucky Medicaid Program for certain surgical procedures is now limited to outpatient coverage unless a life-threatening situation exists, there is another primary purpose for the admission, or the admitting physician certifies a medical necessity requiring admission to the hospital. Among the procedures affected are: local excisions of lesions of the skin and the subcutaneous tissue, dilations of the urethra, vasectomies, gastroscopic exams, and dilation and curettage not associated with pregnancy.
	MD	*A	1/82 (+)	Maryland modified its 20-day limit per spell of illness in acute general hospitals by exempting recipients receiving shock-trauma or neo-natal care in the appropriate specialty referral units of those eleven Maryland hospitals which are designated as part of the Maryland Emergency Medical System.
	MA	*X	2/82 (-)	(H 3938) The Massachusetts legislature reported the introduction of a bill that would limit conditions for payment for administratively necessary days in hospitals. This proposal was dropped.
	MA	*X	2/82 (-)	(H 4810) The Massachusetts legislature has reported the introduction of a bill to eliminate non-emergency weekend admissions. This proposal was dropped.
	MA	*P	2/82 (+)	(H 1953) The Massachusetts legislature reports that a bill has been introduced to provide coverage of persons under 21 in psychiatric hospitals.
	MA	*X	2/82 (+)	(H 3139) The Massachusetts legislature reports the introduction of a bill to provide services for children in certain mental health facilities. This proposal has been dropped.

MA	*P	1/82 (+)	(H 1777) The Massachusetts legislature reports the introduction of a bill to authorize payment for administratively necessary days.
MI	*A	10/82 (-)	Michigan limited coverage of inpatient hospital stays to 18 days per stay. Days beyond this limit must be pre-authorized. This limitation is in addition to the one limiting stays to the 75th percentile of length of stay criteria.
MI	*A	1/82 (-)	Michigan limited inpatient services to the 75th percentile of length-of-stay guidelines based on 1980 data in the Professional Activities Study (PAS).
MI	*A	1/82 (-)	The State of Michigan eliminated coverage of all Friday and Saturday non-emergency hospital admissions.
MI	*A	1/82 (-)	Michigan has dropped coverage of certain surgical procedures when performed in an inpatient hospital setting. These will be covered only in an ambulatory setting. (Ambulatory setting includes out-patient hospital).
MI	*C	/82 (-)	The State of Michigan is considering limiting hospital stays for recipients with a diagnosis of substance abuse to five days for detoxification purposes, with prior authorization required for stays beyond the limitation.
*	MN	*A 6/83 (+)	(SF 1234) The Minnesota legislature enacted a law which increased from 10 days to 30 days the maximum length of stay reimbursable to hospitals and nursing homes for treatment of alcoholism, chemical dependency, or drug addiction.
	MS	*A 11/82 (+)	Mississippi increased coverage of inpatient hospital care from 20 to 30 days per fiscal year.
*	MO	*C 10/83 (-)	Missouri is considering paying for alcoholic detoxification stays only if they are followed by a complete rehabilitation treatment course.
*	MO	*A 7/83 (+)	Missouri has established new lengths of stay for pediatric and rehabilitation diagnoses which may exceed the PAS Length of Stay.



*	MO	*A	6/83 (+)	Missouri added coverage of kidney transplant services, with reimbursement at a fixed fee.
	MO	*A	4/82 (-)	Missouri began disallowing reimbursement as inpatient hospital services for one-day inpatient hospital stays (same day admittance and discharge). These stays are to be billed as outpatient services.
	MO	*A	1/82 (-)	Missouri imposed a 21-day limit on inpatient hospital days for general relief recipients. These patients are limited to the lower of the 21-day limit or the previously-imposed 75th percentile of PAS lengths of stay limit.
	NE	*A	8/82 (-)	Nebraska imposed a limitation of 36 days per calendar year upon the reservation of beds for recipients during therapeutic leaves of absence from ICF/MR facilities.
	NE	*A	6/82 (-)	Nebraska began limiting coverage of inpatient hospital care and physician visits to a certain related percentile (to be determined by the Nebraska Department of Public Welfare) of the West North Central Region Length of Stay in Professional Activity Study (PAS) Hospitals published annually by the Commission on Professional and Hospital Activities, Ann Arbor, Michigan.
	NE	*A	5/82 (-)	Nebraska adopted a limitation on inpatient psychotherapy services of \$500 per calendar year. Services over \$500 require prior authorization.
	NV	*A	4/82 (-)	Nevada began rigid enforcement of a provision limiting preoperative hospital stays to one day, with the exception of selected procedures.
	NH	*A	7/82 (+)	New Hampshire removed its 12-day-per-year limitation on inpatient hospital coverage. The criteria for coverage is now medical necessity, with approval by the P.S.R.O.
	NJ	*A	/82 (+)	The State of New Jersey has begun reimbursing hospitals for administratively necessary patient days. There is a 12-day limit on those administrative days allowed for social necessity; that is, placement in the community. There is no specific day limit for patients awaiting placement in a nursing home; however, the hospital must make prompt efforts to place them.



- \* NM \*A 3/83 (+) New Mexico added coverage of swing bed services, allowing small rural hospitals to use inpatient facilities to furnish ICF and SNF services.
  
- NM \*A 10/82 (-) New Mexico reduced the number of hospital "grace days" from three days to one working day. "Grace days" are days of inpatient hospital care allowed after the PSRO determines the individual no longer requires acute level care, so that he or she may complete arrangements for transfer to his or her home. It was decided that patients should be allowed one working day so the hospital could obtain prior approval from the PSRO for needed services for the client's release (e.g., meals on wheels, wheelchair).
  
- \* NY \*A 4/83 (-) New York added hospital-based ambulatory surgery services in hospitals which receive Certificate of Need approval.
  
- \* NC \*A 7/83 (-) (SB 23) The North Carolina legislature enacted a law which limited to three the number of administrative days covered per period of hospitalization.
  
- \* NC \*A 7/82 ( ) North Carolina added coverage, at a reduced rate of payment, for hospital days used when the inpatient no longer requires hospitalization, but when no beds are available at the appropriate SNF or ICF level of care.
  
- OH \*A 2/82 (+) Ohio tightened its limitation on the number of covered inpatient hospital days per spell of illness from 60 days to 30 days, with additional days now allowed if they are medically necessary. (There was no previous extension for medical necessity).
  
- \* PA \*P /83 (-) Pennsylvania is considering a proposal to limit, by diagnosis, the number of covered hospital days.
  
- RI \*A 4/82 (-) Rhode Island limits to five per hospitalization the number of allowed administratively necessary days provided in a hospital. After five, prior authorization will be required. Administratively necessary days are those days when a patient is no longer in need of inpatient hospital care and is awaiting placement in a community-based SNF or ICF.

SC	*A	1/82 (-)	South Carolina eliminated coverage of inpatient hospital services for General Assistance recipients.	
SC	*A	1/82 (-)	South Carolina reduced coverage of inpatient hospital days from 18 to 12 per year.	
SC	*X	/82 (-)	The State of South Carolina was considering eliminating coverage of elective surgery. Exceptions would be made in cases certified as medically necessary. This proposal was dropped. (Contact: Ken Kamis 803/758-8133).	
*	SD	*A	7/83 (+)	South Dakota extended hospital care coverage to an unlimited number of inpatient hospital days per year. Previously, it allowed 30 days of coverage.
	SD	*A	1/83 (-)	South Dakota reduced the number of allowable hospital inpatient days from 60 to 30 days per benefit period.
	TN	*A	7/82 (+)	In July 1981 Tennessee had eliminated coverage of the following services for most medically needy recipients: inpatient and outpatient hospital services, physician and pharmacy services, prosthetic devices, and Christian Science sanatoria services. Among the medically needy groups still able to receive physician and pharmacy services were nursing home residents. A federal court later ruled that this discriminated by class (according to living arrangements), and required the state to retroactively pay for services denied to medically needy recipients during this period. Tennessee therefore in July 1982 increased coverage for the medically needy; they will now receive the same services as the categorically needy. At the same time, Tennessee reduced its medically needy eligibility population to only pregnant mothers and children under 21 in special groupings.
	TX	*A	4/82 (-)	Texas implemented a new policy for Friday or Saturday admissions for non-cash assistance recipients. If the treatment is not for an emergency (an emergency necessitates medical intervention and hospitalization within 72 hours to prevent death or serious disability), or if surgery is not performed within one day of admission; then a detailed prepayment review will be made (for hospitals that are on "prior to payment review"). If hospitals cannot justify medical necessity, Medicaid will reduce

the claim as if the admission began on Sunday. Accommodation charges on Friday and Saturday will not be covered; ancillary charges for these days will be reimbursed when medically necessary.

- \* UT \*A /83 (-) Utah deleted day hospital program coverage from its state plan. (There were no providers of day hospital services participating in the Medicaid program at the time of deletion.)
- UT \*A 11/82 (-) Utah developed a list of surgical procedures which it judges may be safely and appropriately performed in an outpatient setting. These procedures must be performed on an outpatient basis unless prior authorization for inpatient surgery is obtained.
- UT \*A 5/82 (-) Utah has begun a hospital length of stay limitation program which will be phased in over a three-year period. The ten most frequently diagnosed conditions will be assigned length of stay limitations which will correspond to the lower of the 50th percentile of the Western Region Professional Activities Study or the state's 50th percentile. Longer stays must be medically justified by a physician. On May 10, 1982, the first limitation, two days, was placed upon normal delivery stays for mothers and newborn infants.
- UT \*A 1/82 (+) Utah eliminated its 28-days-per-stay hospital limitation.
- VA \*A 7/82 (-) Virginia discontinued coverage of Friday and Saturday non-emergency hospital admissions.
- VA \*A 7/82 (-) Virginia limited inpatient hospital coverage by allowing admission no more than one day prior to non-emergency surgery.
- VA \*A 7/82 ( ) Virginia established its benefit periods for patients in hospitals at the 75th percentile of the Professional Activities Study (PAS) diagnosis limit, up to a maximum of 21 days per admission.
- VA \*A /82 (-) The Virginia legislature enacted HB 30, which eliminates nursing home reserve bed days while recipient is in the hospital, but requires nursing homes to readmit Medicaid recipients discharged to a hospital at the next available vacancy.



- \* WA \*A 1/83 (-) The state of Washington lowered its hospital length of stay limitation from the 75th to the 50th percentile according to the Professional Activities Study (PAS). Extensions must be approved by the local Medical Consultant.
- WA \*A 11/82 (-) Washington will limit the length of stay of all hospitalized recipients to the 75th percentile according to the Professional Activities Study (PAS). Extensions will be allowed, but only if approved by the local Medical Consultant.
- WA \*A 5/82 (-) Washington implemented a voluntary ambulatory surgery program to achieve a reduction in hospital admissions for surgical procedures which can safely be performed in other than an inpatient setting.
- \* WA \*A /82 (-) The state of Washington implemented a policy allowing small hospitals to convert acute care beds to long term care swing beds.
- WV \*A 1/82 (-) West Virginia reduced its limitation on covered inpatient hospital days from 30 to 20 per year. In making the transition from calendar years to fiscal years as the basis for this limitation, they are allowing a maximum of ten inpatient hospital days for the period from January 1 to June 30, 1982.
- WI \*A 1/82 (+) The State of Wisconsin began providing limited coverage of psychiatric services provided in a special hospital to individuals aged 22-64. Such care must be authorized by the community mental health board, which is responsible for 10-20 percent of the cost of such care. (Inpatient psychiatric coverage for those under 21 and over 64 continue to be covered for the categorically needy, in any hospital setting.) Reimbursement for this service is limited to an episode of care occurring at least 90 days from the date of the last discharge. The counties are responsible for the "state's share," which is 42 percent of costs. The ultimate source of the remaining 58 percent has not yet been determined, pending the outcome of a waiver application.



## B. Utilization Controls

- \* AL \*A 4/83 ( ) Alabama ended its agreement with PSROs to monitor inpatient hospital admissions and perform utilization review. "Alacaaid," Alabama's fiscal intermediary, is now performing these duties.
- CO \*A 8/82 (-) The Colorado Foundation for Medical Care, the Professional Standards Review Organization for Colorado, began providing 100% concurrent review to assure that all inpatient hospital stays are considered medically necessary for the patient's condition. This includes a special focus on weekend hospital admissions.
- \* CT \*P /83 (-) Connecticut has proposed an increase in hospital utilization review efforts.
- \* GA \*A 2/83 ( ) Georgia implemented pre-payment review of all one-, two-, and three-day inpatient hospital claims during the months of February and March 1983 only.
- \* GA \*A 1/83 ( ) Georgia ceased 100% pre-payment review of inpatient hospital claims.
- \* GA \*A 1/83 (+) Georgia removed hysterectomies from the list of services requiring prior approval.
- \* IL \*A 7/83 (-) Illinois imposed a variable copayment on inpatient hospital services. The amount of the copayment depends upon the amount the state pays the hospital for treatment of inpatients: If the hospital's rates are \$325 per day or more, the copayment is \$3 per day. If the hospital's rates are above \$275 and below \$325 per day, the copayment is \$2 per day. If the hospital's rates are \$275 or less, there is no copayment for inpatient services.

Copayments do not apply to General Assistance medical recipients, whose coverage is already limited to a \$500 cap per hospital admission.

Exceptions to the copayment requirement include: (1) individuals under the age of 18; (2) nursing home residents; (3) pregnancy-related services for pregnant women or post-partum women who have given birth within the last six months; (4) emergency services; and (5) family planning services. Hospitals must collect the copayment and show it as a credit on the bill submitted to Medicaid. Providers

cannot deny care when individuals are unable to pay the copayment; however this does not extinguish the individuals' liability for payment of the copay.

- \* IA \*P /83 (-) (HF 196) The Iowa legislature reports introduction of a bill to create a health data commission to gather and publicize cost information from hospitals and third party payors.
- KS \*A 5/83 (-) The state of Kansas proposed prior authorization for 30-day in-hospital substance abuse programs. The criteria for approval would have included the absence of availability of such care through community resources. This was not implemented. However, specific review criteria have been developed for these 30-day programs, and they are reviewed on admission and concurrent stay bases through the hospital utilization review program.
- \* KS \*A 4/83 (+) Kansas rescinded a previous policy requiring verification of medical necessity when any of 137 surgical and diagnostic procedures were done on an inpatient basis. A higher incentive rate will still be paid when these procedures are done on an outpatient basis.
- KS \*A 9/82 (-) Kansas has contracted with two foundations for medical care to conduct statewide hospital utilization review. Review consists of a mixture of delegated, non-delegated, and non-delegated telephone reviews in different counties. There is 100 percent review for Medicaid patients. Admission review is performed within one working day of admission. Continued stay reviews are generally performed every three days.
- KS \*A 7/82 (-) Kansas began conducting onsite reviews of 20-30 percent of all inpatient hospital claims, with emphasis on ancillary services.
- KS \*A 4/82 (-) Kansas ended, as of April 1, 1982, its reliance on PSROs for hospital utilization review. The state is negotiating with several groups in the state to take over the reviews, but in the interim they will be conducted by the individual hospitals. The state is tightening its length of stay regulations. All inpatient hospital stays for Medicaid recipients must be reviewed and be deemed medically necessary, with backup documentation of the review. For those recipients whose lengths of stay equal or

exceed the 75th percentile of stays for their primary diagnosis as listed in the most recent edition of the PAS, North Central Region, a Medical Necessity Form must be attached to the claim.

- \* LA \*P /83 (-) Louisiana proposes to require prior authorization for certain hospital procedures.
- MA \*C 9/82 (-) The Massachusetts Department of Public Welfare is considering expansion of utilization review to include review of ancillary inpatient hospital services.
- \* MI \*P /83 (-) Michigan is considering a proposal to impose copayments on hospital visits.
- MI \*A 10/82 (-) Michigan began requiring prior authorization for inpatient admissions of over 18 days per stay. This requirement is in addition to one limiting stays to the 75th percentile of length of stay criteria.
- MI \*A 1/82 (-) The Michigan Medicaid program began allowing nurse practitioners to recertify inpatient stays for hospitals and nursing homes.
- MI \*A 1/82 (-) The State of Michigan began reviewing all inpatient hospital claims that exceed the 75th percentile of length of stay criteria, as based upon 1980 (PAS) data.
- MI \*A 1/82 (-) Michigan is allowing its contracts with the ten Michigan PSROs to expire. The state will conduct its own utilization review of hospitals, which it anticipates will be less costly and more effective.
- \* MN \*A 6/83 (-) (SF 1234) The Minnesota legislature enacted a law which required second opinions for elective surgeries as identified by the Commissioner of Public Welfare.
- \* MN \*P /83 (-) (HF 742) The Minnesota legislature reports introduction of a bill to require prior approval for chemical dependence treatment exceeding 30 days.
- \* MO \*P 10/83 (-) Missouri is proposing to establish a hospital utilization review unit to monitor appropriate program utilization.
- \* MO \*A 2/83 (-) Missouri implemented a \$10 copayment for each inpatient hospital admission, with the



exceptions listed in TEFRA.

\* MO \*A 7/82 (-) Missouri formed the Hospital Utilization Review Committee, which is an advisory panel for Medical Services. Its duties include:

- Exception review processing;
- Investigation of inappropriate billing practices; and
- Handling problems with hospital review committees.

\* NE \*A 11/82 (-) Nebraska reinstituted the requirement that a physician certify, and recertify every 60 days, that inpatient hospital services are medically necessary. The certification and recertification must be kept on file in the patient's medical record and must be available upon request for review. Exceptions: psychiatric inpatient care must be recertified every 30 days.

NE \*A 6/82 (-) Nebraska revised its hospital policy to more clearly define hospital length of stay and utilization review criteria. (Estimated Savings: \$975,000).

NV \*A 4/82 (-) Nevada began rigid enforcement of a requirement for pre-admission approval, by the PSRO, for all inpatient hospital services, with the exceptions of emergencies. Services will not be covered without pre-admission review.

NJ \*A 3/82 (-) New Jersey began requiring prior authorization for out-of-state non-emergency inpatient and outpatient hospital care.

NM \*A 4/82 (-) The New Mexico PSRO began performing concurrent continued stay reviews of Title XIX eligibles (with certain exceptions) who are hospitalized beyond the 1980 Western Region PAS 50th percentile of length of stays. This review will commence no later than the date of expiration of the 50th percentile length of stay for the diagnosis(es) involved and continue for the remainder of the hospitalization.

Admission review will be accomplished using a focused methodology. Review of these cases will be performed at admission and concurrently throughout the entire stay. The NMPSRO will use the PAS 50th percentile length-of-stay for the Western United States Region for the initial length of stay (LOS), taking into consideration



patient age and diagnosis or procedure. Subsequent length of stay may be assigned using the 75th or 90th percentile as appropriate, but not to exceed seven (7) days per LOS review.

- \* NC \*P /83 (-) North Carolina is proposing to alter its copayment structure by extending copayments to hospital outpatient services for the categorically needy. It also proposes to delete the copayment for inpatient hospital services for the medically needy; and to extend its physician copayment to the categorically needy while lowering the physician copayment from \$1 to \$.50 for all groups. The target date for these changes is April 1984.
- NC \*A 7/82 (-) When full federal funding for PSRO Medicaid reviews terminated, North Carolina introduced a utilization review program conducted by the state agency. The program requires hospitals to file utilization review plans which conform to regulations. A sample of inpatient discharges which exceed a certain, specified percentile of PAS length of stay is reviewed retrospectively by a team of Registered Nurses.
- \* OH \*A 3/84 (-) Ohio has contracted with five agencies across the state to do pre-admission certification of hospital admissions.
- \* OH \*C /83 (-) Ohio is considering a proposal to establish pre-admission review of inpatient hospital services to identify procedures that could be performed on an outpatient basis.
- \* OH \*C /83 (-) Ohio is considering establishment of a program to conduct prepayment review of surgery and specialty services claims.
- \* OR \*P /83 (-) Oregon is proposing, as of January 1984, to contract with a PSRO for pre- and post-admission review of inpatient hospital services provided in general medical hospitals.
- PA \*A 7/83 (-) Pennsylvania imposed more restrictive criteria in utilization reviews of private (as opposed to public) psychiatric hospitals. Since private hospitals frequently treat more acute cases, the length of stay criteria has been shortened.
- PA \*A 7/82 (-) Pennsylvania phased out its use of PSRO's for hospital utilization review (as contracts with PSRO's expired, they were not renewed). The Medicaid program is conducting its own

utilization review for those hospitals no longer under a PSRO.

\* RI \*A 4/83 (-) Rhode Island began requiring prior authorization for all administratively necessary days provided in a hospital. Previously, prior authorization was required for more than five administratively necessary days.

RI \*A 4/82 (-) Rhode Island instituted its own program for utilization review of hospitals, including prior authorization for inpatient hospitalization for tonsillectomies and adenoidectomies, dilation and curettages, and ganglionectomies. It no longer contracts with a PSRO to provide this service.

\* SD \*A 7/83 (-) South Dakota imposed recipient cost-sharing of \$25.00 for each hospital admission for non-emergency services.

\* SD \*A 7/83 (-) South Dakota imposed recipient cost-sharing for rehabilitation hospital services of \$25.00 for each inpatient admission and five percent of the total outpatient charge.

TX \*A 4/82 (-) Texas began undertaking a detailed prepayment review of those hospitals in cases in which a non-cash assistance recipient is discharged on a Saturday or Sunday. If the hospital cannot document medical necessity, the claim will be reduced as if the discharge occurred on Friday.

Accommodation charges for Saturday and/or Sunday will not be covered; ancillary charges on these days will be reimbursed when medically necessary.

TX \*A 4/82 (-) Texas began requiring proof of medical necessity by both physicians and hospitals for non-emergency readmissions of non-cash assistance recipients within 90 days of a previous discharge. If the readmission is not pre-authorized, the claim must be accompanied by documentation of medical necessity.

TX \*A 4/82 (-) Texas began requiring proof of medical necessity for the following surgeries when performed on an inpatient, non-emergency basis for non-cash assistance recipients: tonsillectomy, adenoidectomy, routine hernia repair (e.g., inguinal, femoral, umbilical, etc.), hemorrhoidectomy, cholecystectomy, hysterectomy, and joint cartilage surgery--meniscectomy, arthroscopy. If these procedures are not preauthorized, claims must be accompanied by documentation of the medical necessity for inpatient surgery.

UT \*A 11/82 (-) Utah developed a list of surgical procedures which it judges may be safely and appropriately performed in an outpatient setting. These procedures must be performed on an outpatient basis unless prior authorization for inpatient surgery is obtained.

VA \*A /82 (-) The Virginia legislature enacted HB 30, which imposes on the medically needy a \$30 per admission copayment on inpatient hospital services.

VA \*A /82 (-) Virginia resumed utilization review of hospital services, previously performed by a PSRO.

VA \*A /82 (-) Virginia intensified monitoring of hospital stays lasting from 15 to 21 days.

\* WA \*A 12/82 (+) The state of Washington rescinded the \$85 deductible per hospital admission and \$2 copayment per emergency room visit which it had been charging to medically needy and medically indigent recipients under its Limited Casualty Program (LCP).

WA \*A 11/82 (-) Washington will implement a prior approval program for all nonemergent hospital admissions. All other admissions will require approval by a local Medical Consultant prior to payment.

WA \*A 10/82 ( ) Washington will be contracting with the Washington State PSRO to perform problem-oriented, focused review at each participating hospital to: (1) determine if the services provided in the hospital are medically necessary and appropriate; (2) determine the medical necessity and appropriateness of continued stay at the acute care level; and (3) assess the quality of care rendered.



- WA \*A 7/82 (-) Washington intensified prepayment review of all inpatient hospital claims.
- WA \*A 1/82 (-) Washington adopted a second surgical opinion program for specific elective surgical procedures. Second opinions are required for tonsillectomy/adenoidectomy; hysterectomy; hernia repair; and cholecystectomy.
- \* WI \*A 1/84 (-) The Wisconsin legislature enacted a law which mandates imposition of a deductible of up to \$75.00 on inpatient hospital services.
- WI \*A 7/82 (-) The State of Wisconsin implemented a plan for monitoring PSRO utilization review activities. Data exchange contracts were signed.

### C. Reimbursement

- \* AL \*C /83 (-) Alabama is considering making modifications to its hospital reimbursement methodology. It is studying various options at the present time.
- \* AK \*A 7/83 (-) The Alaska legislature enacted a law mandating prospective reimbursement for hospitals and nursing homes. The agency must promulgate regulations before implementation, which is scheduled for the latter part of 1983.
- \* AK \*A 7/83 (-) (SB 85) The Alaska legislature enacted a law which established the Medicaid Rate Commission to set prospective payment rates for all health facilities, including: hospitals, SNFs, ICFs, ICFs/MR, rehabilitation facilities, inpatient psychiatric facilities, home health agencies, rural health agencies, and outpatient surgical clinics.
- \* AR \*A 1/83 (-) Arkansas standardized its reimbursement policy toward out-of-state hospitals. They will be paid 85% of their charges. The percentage used will be evaluated annually.
- CA \*P 10/82 (-) The State of California will revise its method of reimbursing for inpatient hospital services in areas where the special provider contracting program has not been implemented or for hospitals that are exempt from the contracting program altogether. Reimbursement under this method is the lesser of:



1. Each hospital's customary charges;
2. Each hospital's allowable costs determined in accordance with applicable Medicare standards and principles of reimbursement including Medicare limitations;
3. Each hospital's all-inclusive rate per discharge. Each hospital's rate per discharge will be updated annually to reflect reimbursable changes in factor input prices, service intensity, patient volume, and other items allowed through the administrative adjustment process' appeals process; or
4. The median all-inclusive rate per discharge of the peer group to which each hospital is assigned.

The all-inclusive rate per discharge is based upon the individual hospital's cost experience during a base period related to allowable cost increases for:

1. Pass-through items which are not subject to a hospital cost index, including:
  - a. Depreciation;
  - b. Rents and leases;
  - c. Interest;
  - d. Property taxes and license fees;
  - e. Electricity, natural gas, and water;
  - f. Hospital malpractice insurance; and
  - g. Medicare allowable return on equity capital for proprietary facilities.
2. Non-pass-through items for which a rate of increase in national economic indices is used, including food, drugs, and professional fees; and
3. An additional one percent for increases in service intensity. The allowable increases in salary, wage, and benefit costs of each hospital will not be allowed to exceed a percentage of the hospital's prior year salary, wage, and benefit costs that correspond to relevant nationwide indices.

Hospitals have been assigned to various peer groups based on similar or common characteristics. Hospitals with average costs per discharge that exceed their peer group median will

be reimbursed at the peer group median. The Department of Health Services will evaluate the peer grouping system at least annually.

Disproportionate-share hospitals (serving low income patients for which the revenues generated are greater than 31% of the total gross revenues of the hospital) with costs per discharge above the peer group median will be additionally reimbursed on a sliding scale for costs above the peer group median.

A court challenge has halted implementation of the peer group system. The parties are presently negotiating on an out-of-court settlement. The resultant reimbursement system will be a modification of this proposal, and will be retroactive to December 1982. For more specific information regarding the peer group system, contact Alan McCready at 916/324-4243.

CA \*A 9/82 (-)

The California legislature provided for the creation of a special hospital negotiator in the Governor's Office. Effective July 1, 1983, the negotiator becomes the Executive Director of the California Medical Assistance Commission.

The law empowers the special hospital negotiator (and later, the commission) to negotiate contracts with a variety of providers, organized delivery systems, and private insurance carriers for institutional and noninstitutional services to program beneficiaries. Foremost among these providers are acute care hospitals:

The special hospital negotiator is authorized to negotiate the rates, terms and conditions of contracts with acute care hospitals for the provision of inpatient services to Medi-Cal beneficiaries. The negotiator must consider the following factors in negotiating contracts or drawing specifications for competitive bidding:

- Beneficiary access.
- Utilization controls.
- Ability to render services efficiently and economically.
- Demonstrated ability to provide or arrange needed specialized services.
- Protection against fraud and abuse.

- Other factors which would reduce costs, promote access, or enhance the quality of care.
- Capacity to provide a given tertiary service on a regional basis.
- Recognition of the variations in severity of illness and complexity of care.

The following types of hospitals are exempt from the contracting program and will continue to be eligible to participate in the Medi-Cal program without entering into contracts:

- Out-of-state hospitals.
- HMOs and other organized health systems.
- State hospitals.
- Children's hospitals and charitable research hospitals as defined in Section 10178 of the California Insurance Code for FY 1982-83.

The following types of beneficiaries are exempt from the contracting program and will be able to obtain care at any inpatient facility in the state:

- Beneficiaries in life-threatening emergency situations or situations that could result in permanent impairment.
- Beneficiaries who live or reside farther than the community travel time standard from a contract hospital, as defined by the Department, if the hospital providing services is closer than a contract hospital.
- Beneficiaries who are also eligible for hospital services under the Medicare program Part A.

All current utilization controls will remain in effect.

- |    |    |          |   |
|----|----|----------|---|
| CA | *X | 1/82 (-) | The California Budget Act of 1981 limited cost of living adjustments for hospital inpatient discharges to 6% for state fiscal year 1981-82, but the federal courts overturned this provision. |
| CT | *X | 2/82 (+) | (H 5391) The Connecticut legislature reported the introduction of a bill to set up appeals procedures for hospital rates to conform to federal rules. This proposal was dropped.              |

CT \*A 1/82 (-) The State of Connecticut implemented a combined audit program with Blue Cross/Blue Shield in order to ensure that Medicaid does not reimburse hospitals at a higher level than Medicare.

CT \*C /82 (-) The State of Connecticut is actively considering revising its approach to reimbursement for inpatient hospital services.

CT \*C /82 (-) The State of Connecticut is considering changing the rate of reimbursement for administratively necessary inpatient hospital days. Presently, administrative days are paid at the regular rate.

\* FL \*A 7/83 (+) Florida began paying hospitals for both concurrent and non-concurrent nursery days. Prior to July 1983, Florida did not pay for concurrent nursery days; that is, it did not pay for a baby's hospital stay at the same time it was paying for the mother's hospital stay.

\* FL \*X /83 (-) (SB 988) The Florida legislature considered a bill which would establish an all-payor prospective rate-setting system for inpatient hospital services. Hospital budgets would be approved unless operating expense increases exceed inflation plus a 3 percent technology factor plus a 1 percent population growth factor. The bill authorizes the collection of a case-mix data set to include total charges and the minimum Uniform Hospital Discharge Data Set adopted by USDHHS. This proposal did not pass.

\* GA \*A 3/83 (-) Georgia mandated certain surgical procedures to be done on an outpatient basis, unless medical justification for admission can be documented.

GA \*A 1/83 (+) Georgia adopted a new prospective hospital reimbursement system. It will pay institutions at a hospital-unique, per case reimbursement rate. The penalty for excess numbers of admissions (beyond 105% of 1982 admissions) will be reduced reimbursement. Initially the program will use 1980-audited costs as a base and will trend those costs forward to establish calendar year 1983 costs per case. Subsequent years' rates will be determined from updated, audited cost reports. The hospital may appeal in cases of catastrophic illness. (Contact: Jim Connolly 404/656-4382).



ID \*A 7/82 (-) Idaho reduced its outpatient hospital interim rate from 100 percent of billed charges to a lower percentage of billed charges based on a cost audit.

\* IL \*A 7/83 (-) Illinois made the following changes to its inpatient hospital reimbursement system:

- Inpatient hospital utilization maximums established in the previous fiscal year for individual hospitals served as the basis for new utilization maximums. Modifications were made where there were changes in caseload, changes in coverage of program eligibility categories, and to correct documented errors, to take into account hospitals' actual utilization experience, and for any re-allocation of days for hospital inpatient service bidding and other capitation programs. Inpatient utilization maximums will be established for each six-month period in the fiscal year to accommodate hospital inpatient service bidding and other capitation programs.
- Hospitals are grouped into seven peer groupings:
  1. Acute care--major teaching hospitals, 22 or more programs;
  2. Acute care--major teaching hospitals, 4 to 21 programs;
  3. Acute care--hospitals offering a high number of complex services;
  4. Acute care--hospitals offering a mix of complex and non-complex services;
  5. Acute care--small hospitals offering few complex services;
  6. Non-acute care hospitals;
  7. Specialty hospitals.

For Groups 1 through 6 the average of the DRI updated costs for individual hospitals within a group is calculated. The final rate for a hospital with DRI updated costs greater than its group mean will be the group mean updated costs. The final rate

for a hospital with DRI updated costs less than or equal to its group mean will be the hospital's DRI updated costs.

An average DRI updated cost for hospitals in Group 7 will not be calculated. The final rate for each hospital in Group 7 will be its own DRI updated costs. For all seven groups, the interim payment rate to be used in reimbursing hospitals during the rate year will be the final rate as adjusted.

- Since the legislature did not fully fund the program, the hospital methodology was amended in the following way: The Agency stated that it would pay the final rates, subject to available funds in the rate year. To the extent that sufficient funds were not available, the agency would defer the unaffordable portion of the rates into later years, subject to the availability of funds in those years, and would reimburse hospitals during the rate year at interim payment rates. For Fiscal Year 1984, there was to be a deferment of 26 percent of the calculated rates. However, litigation ensued, and the court ruled that the state must pay the final rather than the interim rate for services performed on or after December 5, 1983. This matter is being appealed by the state.

- \* IL \*A 7/83 (-) Illinois limited inpatient hospital reimbursement for General Assistance recipients of medical care to a maximum of \$500 per admission. Plans to eliminate coverage of laboratory and transportation services for this group were dropped.
- \* IL \*C /83 (-) Illinois is considering the establishment of a multi-year 100 percent prospective hospital reimbursement system (with no retrospective reconciliation) which groups hospitals in order to measure and reimburse the provision of services in an economical manner.
- IL \*A 7/82 (-) Illinois revised its hospital reimbursement methodology for state FY 1983: (1) The average statewide increase in interim rates will be held to two percent; (2) Included in the budget was a mandated 18 percent reduction in inpatient hospital utilization, saving an

estimated \$127 million. To implement this initiative, hospitals were assigned reductions in their inpatient utilization maximums proportionate to their volume of days beyond the 80th percentile of lengths of stay in 219 primary diagnostic groups. Thus, hospitals with longer stays were assigned larger utilization reductions. The utilization reductions ranged from 0 percent to over 30 percent, but averaged 18 percent below that anticipated by hospitals for Fiscal Year 1983, based on past experience. These reductions were applied to institutions for the year, rather than on a claim-by-claim basis.

IL \*A 1/82 (-) The State of Illinois established an alternative reimbursement methodology for hospital inpatient, outpatient, and clinic services, effective retroactively to October 1, 1981. To establish reimbursement rates for these services, the state first made an estimate of the utilization levels for these services for each hospital. After hospitals were given an opportunity to revise these estimates, each hospital's fiscal year 1979 cost per unit of service was updated to January 1, 1981 using a hospital inflation rate developed by Data Resources, Inc. (DRI). The DRI updating factors ranged from 29.7% for hospitals with fiscal years ending in January 1979, to 20.1% for hospitals with fiscal years ending in December 1979.

The state then calculated expected spending for hospital services for October 1 through June 30 by multiplying each hospital's updated DRI figure by its estimated utilization and totaling the amounts for all hospitals. Because the DRI updated figures exceeded available funds, the figures were then reduced 14.27% for all hospitals. However, in order to provide special relief to hospitals serving a disproportionately high volume of Medicaid patients, the adjusted DRI figures were increased by an amount equal to 3% of the reduction for each percent of Medicaid utilization between 25% and 35% Medicaid, plus 1% for each 1% over 35% Medicaid. (For example, a hospital with 15% Medicaid utilization had its DRI figure reduced by 14.27%; a hospital with 35% Medicaid utilization had its DRI figure reduced by 10.60%; and a hospital with 50% Medicaid utilization had its DRI figure reduced by 8.77%). If the final rate, calculated as described above, is less than or equal to a hospital's current



rate, the hospital will be paid at this calculated rate for services rendered after September 30, 1981, and payable from the fiscal year 1982 appropriation. If a hospital's current payment rate is less than this calculated rate, the hospital will be paid at its current rate.

New hospitals or hospitals that have significantly restructured since their fiscal year 1979 may notify the state that they have restructured, submit supporting documentation (such as certificate of need) and request a rate review. These hospitals may have artificially low rates because the restructuring has not been taken into account by this updating methodology.

In addition to the above adjustments, hospitals that have a high percentage of government payors and that may suffer extreme financial hardship as a result of this rate methodology may request special consideration for potential, severe cash flow problems. To qualify, at least 65% of the hospital's total inpatient days must be reimbursed under Medicare, Medicaid, general assistance and aid to the medically indigent and at least 20% of the total inpatient days must be reimbursed by Medicaid. The hospital must submit its most recent audited financial statement and any other financial and legal documents which would establish that the hospital has insufficient funds to meet its cash flow requirements, including a cash flow statement for July 1, 1981 through June 30, 1982. A \$6.5 million pool has been set aside to assist these hospitals, with the allocation of this amount among qualifying hospitals determined by a panel of hospital fiscal experts.

IL \*A 1/82 (+) The State of Illinois, as part of its revised hospital reimbursement methodology (see above) removed the reimbursement limits on state-funded general assistance and medically indigent hospital services which were set in July, 1981 (see earlier entry).

\* IL \*A 1/82 (-) Illinois ceased payment, under its inpatient hospital coverage, for non-emergency surgical procedures which have been identified as surgeries which may be performed safely in an outpatient setting. Exceptions are made for documented medical necessity or when the patient is in the hospital for an unrelated



condition and/or performance of an unrelated procedure.

- \* IL \*A /82 (+) Due to a lawsuit settled in 1981 (Chicago Hospital of Osteopathic Medicine v. Thompson), Illinois' hospital reimbursement methodology for Fiscal Year 1982 was modified: Hospitals' final, reconciled rates were not reduced by 14.27 percent across the board (with certain exceptions) as previously established; but were adjusted case-by-case, based upon the individual hospitals' efforts at efficiency and economy.
- \* IN \*C /83 (-) Indiana is engaged in a study of its current hospital reimbursement methodology. It is considering various alternative approaches and their desirability.
- IN \*A 1/82 (-) The Indiana legislature enacted a law which required the state's Department of Public Welfare to examine the need for changes in rate structure for institutional services, and to make recommendations concerning Medicaid hospital costs (SB299).
- IA \*A 10/82 (-) Iowa adopted a prospective inpatient hospital reimbursement system. The hospital's FY 1981 Title XIX inpatient cost per diem will be used as the base rate, and annual percentage increases will be based upon projected cost increases in major areas of hospital expenses. (Contact: Charles Ballinger 515/281-5147).
- IA \*A 1/82 (-) Iowa reduced reimbursement to the maximum SNF or ICF payment rate for recipients in hospitals when it is determined that they do not require acute hospital care.
- KS \*A 7/83 (-) The state of Kansas implemented a prospective reimbursement system for inpatient general hospital services, based on a per diem concept. Rates established for each hospital for fiscal year 1984 are based on the hospital's 1981 cost report information. An annual review will be performed each year thereafter. There will be no denials for individual services; hospitals are allowed discretion in the provision of services. However, they are at risk for these services, and will receive only a flat per diem. Out-of-state hospitals which have not filed a cost report will be paid at a rate equaling the average rate of the lower cost

Kansas hospitals or the hospital charges, whichever is less.

- \* KS \*A 4/83 (-) Kansas began reimbursing physicians and hospitals for normal total CB deliveries at a higher rate if the mother is in the hospital 48 hours or less. Previously, the higher rate could only be paid if the mother stayed 24 hours or less.
- \* KS \*A 10/82 (-) Kansas revised its hospital reimbursement methodology by ceasing the allowance of Hill-Burton obligations, including them in the definition of charity allowances, and by eliminating the private room subsidy by deducting the private room cost differential from the cost report. These changes paralleled changes which TEFRA brought about in the Medicare program.
- \* KS \*A /82 (-) Kansas began reimbursing for normal OB deliveries at a higher rate if the mother is in the hospital 24 hours or less.
- KY \*A 3/82 (-) The state received approval from HCFA to implement a new hospital reimbursement policy. The change was from a Medicare-based reimbursement approach to a prospective payment system for inpatient services which established a rate of payment for the hospitals' fiscal year based on prior year inpatient costs and a consumer price index factor to reflect current year cost increases. This index has general applicability to all participating hospitals and, if necessary, is adjusted at the end of the fiscal year to reflect the actual change in the index. No other adjustment is made in the prospective rate established at the beginning of the fiscal year. Components of the reimbursement approach include the application of a minimum occupancy factor of 60 percent to facilities with 100 or fewer beds, and an occupancy factor of 75% to facilities of more than 100 beds for the purpose of determining allowable capital costs. (Contact: Ronnie Cohorn 502/564-7540).
- LA \*P 1/83 (-) Louisiana proposes to implement prospective reimbursement of hospitals in 1983.
- LA \*A 4/82 (-) Louisiana instituted an exception to the Medicare reimbursement principles for inpatient hospital services. For acute hospital facilities, it will no longer allow costs for non-Medicaid indigent patients.

- \* ME \*A 7/83 (-) (SB 608) The Maine legislature enacted a law which established a prospective, mandatory all-payor rate-setting system for reimbursing inpatient hospital services. The Act establishes a Health Care Finance Commission, appointed by the Governor, to administer the program in consultation with three advisory committees composed of professional, hospital, and payor representatives. The Commission will seek a Medicare waiver. The Commission is responsible for establishing and apportioning revenue limits for each hospital by computing financial requirements minus available resources plus revenue deductions. Major third party payors pay by periodic interim payments; other purchasers pay on the basis of charges established by the hospital not to exceed the portion of the revenue limit allocated to this group. The Act also establishes the Management Support Fund to support improvement in management and information systems. The Fund is derived from revenues received by hospitals pursuant to a specific adjustment to financial requirements. Assets of the Fund will be used to assist small hospitals in developing the capabilities necessary to function under the new reimbursement system. Finally, the Act establishes a statewide limit on total annual capital and non-capital costs subject to CON approval. The limit is set at 1 percent of hospital financial requirements.
- ME \*A 1/82 (-) Maine modified its method of reimbursing for hospital services provided to inpatients awaiting transfer to a SNF or ICF. Payment for these administratively necessary days will be set at the statewide average rate for SNF or ICF care, except that payment shall not be lower for hospitals which have no excess of beds.
- MA \*A 10/82 (-) Massachusetts has received a federal waiver to permit Medicaid participation in an experimental full-payor participation prospective acute hospital reimbursement system. Hospitals are paid a prospectively-determined maximum allowable cost, with some adjustment at the end of the hospital's fiscal year based on actual costs. Some cost areas are recognized at the marginal cost level; while others, such as outpatient services, are paid at higher than the marginal cost level. The hospital is at risk, which encourages efficient and prudent



operation. The various payors' shares are determined by calculating their proportional share of charges. Medicaid pays at a variable rate (average : 72 percent) of the maximum allowable cost. Under this system, Medicaid for the first time allows for some free care. In addition, a productivity factor, which averages approximately 1-1/4 percent, is subtracted from the hospital budget after any increases for inflation and volume are figured in.

- MA \*A 7/82 (-) Massachusetts reduced payments to chronic care hospitals to reflect the level of care actually being received. Patients at a less than chronic care hospital level of care are reimbursed at an institution-specific rate commensurate with the resources needed to care for a patient at that level of care.
- MA \*X 1/82 (-) (H 493) The Massachusetts legislature reported that a bill was introduced to limit reimbursement for intensive care services to 3 times the cost of the lowest priced bed. This proposal has been dropped.
- \* MI \*A 7/83 (-) (HB 4558) Michigan's Appropriations Act requires hospital payments for costs associated with graduate medical education programs unless the program has been identified as unnecessary.
- MI \*A 7/82 (-) The State of Michigan revised the prospective hospital reimbursement system as approved January 1982 by adding a limitation on operation costs. Hospitals are paid Medicaid's share of the lesser of the customary charge to the general public or efficient cost plus incentive payments. Efficient cost is the lesser of either reasonable cost or the individual hospital operating cost limitation (IHOCL). The IHOCL is current year excluded plus education costs plus the class-wide 75th percentile of adjusted operating costs per patient day (from the class of hospitals in which the hospital is included) times the hospital's: (1) Casemix Index, (2) HCI, (3) Area Wage Level Adjustment, (4) High Medicaid Volume Adjustment, and (5) Total Inpatient Days. The definitions of reasonable cost, allowable cost, the HCI, included costs and base period included costs were unchanged from the January 1982 system. New definitions were included for operating costs (included cost less education costs), education costs (as



defined by Medicare) and incentive payments (as before but except that reasonable cost plus incentive payments may not exceed the IHOCL).

- MI \*A 4/82 (-) The State of Michigan revised the prospective hospital reimbursement system, as approved effective October 1981, by including the Medicare 223 limitation into prospective and cost-settled rates (the state had a waiver to the limits effective with the January 1980 system, subject to the requirement that aggregate reimbursement under this system of reimbursement not exceed what it would have been, had hospitals been reimbursed under the Medicare system of reimbursement). Hospitals are paid Medicaid's share of the lesser of customary charge to the general public or reasonable cost plus incentive payments. Reasonable costs are the lesser of: (1) current year allowable costs, (2) base period included costs updated by the HCI, plus excluded costs from the current year, or (3) reimbursable costs per Medicare. The definitions of allowable costs, the HCI, included costs, incentive payments and base period included costs were unchanged from the October 1981 system.
- \* MN \*A 10/83 (-) Minnesota will implement, effective October 1983, a prospective reimbursement system for inpatient hospital services. The system will be phased in with the hospitals' fiscal years and will be related to DRGs, paying on a cost per admission, rather than a cost-per-day, basis. In the initial phase, Minnesota will use only one overall DRG for hospitals, calculating the average cost per admission for the base year of 1981 and adjusting it for inflation. This average cost-per-admission figure will include both routine and ancillary costs.
- \* MO \*A 3/83 ( ) Missouri began making guaranteed periodic interim payments to hospitals based on their previous fiscal year average payments. Payments are adjusted quarterly to actual expenditures.
- \* MO \*C /83 (-) Missouri is considering revision of its methodology for reimbursement of hospital-based physicians.

- MO \*A 7/82 ( ) Missouri implemented fiscal year-end adjustments of their payments to hospitals: Medicaid allowable charges are compared to payments made.
- MO \*A 7/82 (-) Missouri revised its inpatient hospital reimbursement plan to include a utilization factor and to use a more conservative estimate of inflation such as the Consumer Price Index instead of the Market Basket.
- MO \*X 1/82 (-) (HB 1089) The Missouri legislature reported the introduction of a bill to revise its cost-related reimbursement systems for inpatient hospital and nursing home services. This bill did not pass.
- \* NE \*A 7/83 (-) Nebraska extended indefinitely its prospective reimbursement system for hospitals beyond June 30, 1983. (The system had been in effect on a trial basis from July 1, 1982 to June 30, 1983.)
- NE \*A 7/82 (-) Nebraska adopted a prospective reimbursement system for inpatient hospital services. This system will be in effect from July 1, 1982 to June 30, 1983 on a trial basis.
- \* NV \*A 9/83 (-) Nevada implemented a prospective hospital reimbursement system. Rates were established after an eighteen-month study of the former reimbursement rates, and were set at the level of an individual hospital selected for its efficient operation and its average or slightly-higher-than-average case mix intensity. A single statewide rate was set for the four following types of stays:
- obstetrical;
  - newborn, nursery;
  - neo-natal, intensive;
  - stays of over 15 days (16 days and over are reimbursed at a per diem rate).
- For routine stays of one to fifteen days a single rate was set for each of three categories of hospitals, determined by bed size, case mix, and facility specialties.
- NV \*A 10/82 (-) Nevada began reimbursing individual hospitals for administratively necessary days at the statewide average all-inclusive SNF or ICF rate, as appropriate.

- \* NH \*A 3/83 (+) New Hampshire re-implemented reimbursement for inpatient hospital services at 100% of allowable costs, following Medicare principles.
- NH \*C /83 (-) New Hampshire is considering a prospective reimbursement system for inpatient hospital services.
- NY \*A 1/83 (+) (S 5226-B; A 7303-B) The New York legislature passed a bill in 1982 providing for prospective cost-based rates based upon revenue caps for each hospital which would distribute costs among various payors including Medicare, Medicaid, and other third party payors.

The revenue caps use a formula based on an inflation factor and are subject to limits and ceilings based on peer groupings. They include additional allowances above the revenue cap for bad debt and charity care and discretionary funding, the use of regional pools to distribute bad debt and charity funds, and uniform reporting by hospitals. The new system is expected to add \$430 million to hospital revenues over three years and to reduce the differential between Medicaid and Blue Cross and commercial insurers to about 12% at the end of four years. Its implementation began in January 1983, upon the receipt of a waiver from HCFA.

- NY \*A 1/82 (-) New York established discrete alternate level of care rates. These rates are for services provided by a hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that skilled nursing or health-related services are medically necessary and are being provided by the hospital since they are not otherwise available.
- NC \*A 7/82 (-) North Carolina revised its prospective reimbursement plan so higher cost hospitals are paid their full per diem for only a specific number of patient days. After exceeding this number of days, higher cost hospitals are paid a per diem equal to the average per diem of lower cost hospitals.
- \* OH \*A 7/84 (-) Ohio is currently working on the implementation of a DRG prospective payment system for hospitals.



- \* OH \*A 10/83 (-) Ohio adopted target rate provisions of TEFRA to place an overall incentive ceiling on the growth of hospital expenditures.
  
- OH \*A 1/83 (-) The Ohio legislature enacted S.B. 530, which reduces interim payments to hospitals and nursing homes except ICFs/MR if expenditures are estimated to be greater than appropriations. Adjustments to recoup reductions will be made in FY 1984.
  
- OH \*P /82 (-) Ohio is considering reimbursement of inpatient hospital services on a prospective basis, using the 1982 federal Medicare hospital reimbursement regulations as a basis.
  
- \* OK \*A 4/83 (-) Oklahoma implemented a new prospective per diem reimbursement system for inpatient hospital services. For each facility, separate rates are set for the various levels of care (e.g., intensive care, nursery, coronary care, and burn care). Rates are established at the lower of either: (a) the figures in each hospital's cost reports for specific periods of time, adjusted for inflation, or (b) the 60th percentile of costs reported by all general care hospitals in the state.
  
- \* OR \*A 7/83 (-) Oregon adopted a new methodology for inpatient hospital reimbursement, effective July 15, 1983. The state now pays, on a prospective basis, a hospital-specific flat rate per discharge. Oregon previously used the Medicare reasonable and customary methodology.
  
- \* PA \*A 7/83 (-) Effective 7/1/83, Pennsylvania limited annual increases in hospital interim per diem rates to 8 percent of the rate in effect the prior fiscal year. Audited per diem rates are limited to 7.8 percent of the previous year's rates for regular hospitals, and to 8.4 percent for exceptional hospitals those hospitals serving a disproportionate number -- over 24 percent -- of low income patients with special needs).
  
- \* PA \*P /83 (-) Pennsylvania is proposing to implement a prospective hospital reimbursement system based on diagnosis-related groups (DRGs). This system would apply to all general hospitals (it would not cover rehabilitation, private psychiatric or other special hospitals). Its target date for implementation is July 1, 1984. This initiative was recommended by the



Governors' Health Care Cost Containment Task Force.

- \* PA \*P /83 (-) Pennsylvania is proposing to adopt regulations in 1984 to pay \$10 a month as a case management fee to physicians who supervise recipients under the lock-in program.
  
- PA \*A 7/82 (-) Effective 7/1/82, Pennsylvania limited annual increases in interim per diem rates paid for inpatient hospital services to 10% of the average interim rate in effect as of June 30, 1982. A hospital's audited per diem rate was limited to an annual increase of 9.8% over the hospital's audited per diem rate for the preceding fiscal year. If a hospital qualified as serving a disproportionate number of low income patients with special needs in accordance with the Department's established criterion, the hospital was limited to an increase of 10.5% over its audited per diem rate for the preceding fiscal year. In addition, costs related to new construction projects which began operation in the fiscal year were passed through the limit.
  
- TN \*P /82 (-) The State of Tennessee is considering a proposal to reimburse hospitals at a rate not to exceed the 75th percentile of reasonable costs.
  
- \* TX \*C /83 (-) Texas is considering altering its hospital reimbursement methodology.
  
- TX \*A 2/82 (-) Texas began paying, for major surgery, one global surgical fee, which includes post care for up to six weeks. For extensive surgery for which follow-up care is long term, post care included in the global surgical fee is six months. For elective surgical admissions, the admission history and physical is included in the global surgical fee.
  
- UT \*A 1/83 (-) Utah placed on its inpatient hospital reimbursement system additional payment constraints based upon increases in the base year.
  
- \* UT \*A /83 (-) Utah implemented a new prospective hospital reimbursement methodology in which payment rates vary according to diagnosis-related groups (DRGs). This methodology, implemented on a statewide basis, differs from the Medicare model.

UT \*A 10/82 (-) Utah adopted the new Medicare payment limits.

\* VT \*A 7/82 (-) Vermont instituted a prospective, all-inclusive per diem reimbursement system for hospitals.

VA \*A 7/82 (-) Virginia established the following hospital reimbursement policies:

1. Hospitals will be grouped by classes according to number of beds and urban versus rural. (Three groupings for rural--less than 100 beds, 101 to 170 beds, and over 171 beds; four groupings for urban--less than 100, 101 to 400, 401 to 600, and over 601 beds). Groupings are similar to those used by the Health Care Financing Administration (HCFA) in determining routine cost limitations.
2. Prospective reimbursement ceilings on allowable operating costs will be established as of July 1, 1982, for each grouping. Hospitals with a fiscal year ending after June 30, 1982, shall be subject to the new reimbursement ceilings.

The calculation of the initial group ceilings as of July 1, 1982, will be based on available allowable cost data for all hospitals in calendar year 1981. Individual hospital operating costs should be advanced by a reimbursement escalator from the hospital's year end to July 1, 1982. After this advancement, the operating costs will be standardized using Standard Metropolitan Statistical Area (SMSA) wage indices, and the median should be determined for each group. These medians will be re-adjusted by the wage indices to set an actual cost ceiling for each SMSA. Therefore, each hospital grouping will have a series of ceilings representing one for each SMSA area.

The wage index will be based on those used by HCFA in computing its Market Basket Index for routine cost limitations. The reimbursement escalator will be the twelve-month average of the Bureau of Labor Statistics Consumer Price Index (CPI) adjusted quarterly. This index will have excluded from it housing and interest components since the ceilings only

apply to operating costs. The quarterly ceilings will be used for hospitals which have a fiscal year beginning within the quarter.

3. Subsequent to June 30, 1982, the group ceilings will not be recalculated on allowable costs, but will be updated by the escalator.
4. Prospective rates for each hospital will be based upon the hospital's allowable costs plus the escalator, or the appropriate ceilings, or charges, whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustment will be made to prospective rates.
5. Depreciation, capital interest, and education costs approved pursuant to HIM-15 (Sec. 400), will be considered as pass-throughs and not part of the calculation.
6. Hospitals which have a disproportionately higher level of Medicaid patients and which exceed the ceiling will be allowed a higher ceiling based on the individual hospital's Medicaid utilization. This will be measured by the percent of Medicaid patient days to total hospital patient days. Each hospital with a Medicaid utilization of over 8% will receive an adjustment to its ceilings. The adjustment will be set at a percent added to the ceiling for each percent of utilization up to 30%.
7. An incentive plan will be established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 25% of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive will be calculated based on the annual cost report.

\* WA \*C /83 (-) The state of Washington is considering establishing an all-payor system for hospital reimbursement.



- WA \*A 7/82 (-) The state of Washington implemented a hospital reimbursement system based on prospectively determined payment rates. Each hospital's rate is the ratio of approved operating expense, minus a salary and wage component, to approved total rate-setting revenue. This system included a wage component limitation plan which was rescinded on December 15, 1982.
- \* WV \*A 7/83 (-) (SB 320) The West Virginia legislature enacted a law which established, as of July 1, 1983, the West Virginia Health Care Cost Review Authority, a three-member board that will review, investigate and approve hospital rates and budgets (for all payors) and will review CON applications. The Board must allow sufficient funds to meet the federal requirement that they will be "reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated hospitals..." and must make allowances for hospitals caring for a disproportionately large number of needy patients. Medicaid recipients must also be assured adequate access to inpatient hospital care.
- \* WV \*A 7/83 (-) (SB 320) The West Virginia legislature enacted a law which, in conjunction with the establishment of a West Virginia Health Care Cost Review authority charged with setting hospital rates, froze inpatient hospital rates at the February 1983 level until the Board could formulate a rate schedule, and limited increases in hospitals' gross patient revenues to 12 percent per year. (The 12 percent limit would be adjusted if a hospital changed its patient mix in regard to Medicare, Medicaid or charity patients.) The U.S. District Court issued a preliminary injunction against both the rate freeze and the 12 percent revenue limit while it considers the constitutional and statutory questions involved.
- WV \*A 3/82 (-) West Virginia reduced interim payments for inpatient hospital services by 15% through June 30, 1982.
- WI \*P /83 (-) The State of Wisconsin has developed standards for determining educational and research costs incurred by a hospital that are not directly related to patient care and thus not allowable for reimbursement purposes. By statute, standards must be reviewed/approved by the state legislature's Joint Finance Committee



prior to implementation. The standards are pending legislative action.

\* WI \*A /83 (-) (SB 83) The Wisconsin legislature enacted a law establishing a mandatory hospital rate-setting commission. The commission has wide authority to move to an all-payor system. Medicaid is not included, but the Act authorizes Medicaid to join the system. The Act also provides that by 1987 the Commission set hospital rates by diagnostic related groups (DRGs).

### 3. Outpatient Hospital Services

#### A. Amount, Duration and Scope

- \* AL \*P /83 (-) Alabama is proposing to reduce the number of outpatient visits from six visits to three visits per recipient per year.
- CA \*A 7/83 ( ) (AB 3219) The California legislature enacted a law which requires the state Department of Health Services, by July 1, 1983, to establish a sub-acute care program in health facilities to be available to patients who meet sub-acute care criteria. Under the new law, the sub-acute care may be provided by any facility, designated by the Director as meeting the sub-acute care criteria, which has an approved participation agreement with the Department. Reimbursement at the sub-acute care rate would only be implemented when the annual budget act provides funds for this purpose. The law also requires the Department to develop a reimbursement rate and to establish a definition of sub-acute care, level of care criteria and appropriate utilization controls for the patients eligible for the sub-acute care program.
- FL \*A 1/82 ( ) (HB 546 and S 279) The Florida legislature reported that a law had been enacted extending a pilot project, initiated in October 1978, which had raised the cap on outpatient hospital services per year from \$100 to \$500 in exchange for contributions by Florida counties of a percentage of their indigent care incomes. There were also discussions about dropping the project and lowering the \$500 cap to the pre-1978 \$100 level. The Florida legislature passed SB 279, which maintains the outpatient cap at \$500 through June 1983. Optional funding strategies are under consideration.
- IL \*A 7/82 (-) The State of Illinois eliminated coverage of many hospital outpatient services for its non-pregnant AFDC adult medically needy only, general assistance, and aid to the medically indigent recipients.
- \* KS \*A 7/83 (+) Kansas began covering one outpatient sonogram per pregnancy (nine months). Medical necessity documentation is required for a subsequent sonogram per recipient per nine months.

MS	*A	11/82 (+)	In Mississippi, the number of visits reimbursable for physician services rendered in a physician's office, outpatient department of a hospital, or rural health clinic is increased from 12 to 18 per fiscal year.	
MO	*A	11/82 (-)	Missouri limited emergency room and outpatient visits to two per month, with an exception for those outpatient visits that would otherwise be performed on an inpatient basis, i.e., chemotherapy visits. (The majority of hospitals in Missouri do not have distinct parts for the emergency room as separate from the outpatient clinic. Therefore, the limitation is for any combination of such visits in a calendar month).	
MO	*X	3/82 (-)	Missouri proposed to allow only one emergency room/outpatient hospital facility charge per recipient per day. This proposal was dropped.	
*	NH	*A	7/83 (+)	New Hampshire raised its ceiling on physician outpatient services from 12 to 18 visits per recipient per fiscal year.
NC	*A	7/82 (+)	North Carolina increased from 18 to 24 the number of allowed visits to one or a combination of the following: outpatient hospital departments (excluding emergency rooms); rural health clinics; physicians; clinics (except mental health centers); optometrists, podiatrists, chiropractors. Exemptions from the limitation did not change.	
OH	*A	1/83 (+)	Ohio reinstituted coverage of outpatient health facility services (OHFs). OHFs will be reimbursed prospectively.	
TN	*A	7/82 (+)	In July 1981 Tennessee had eliminated coverage of the following services for most medically needy recipients: inpatient and outpatient hospital services, physician and pharmacy services, prosthetic devices, and Christian Science sanatoria services. Among the medically needy groups still able to receive physician and pharmacy services were nursing home residents. A federal court later ruled that this discriminated by class (according to living arrangements), and required the state to retroactively pay for services denied to medically needy recipients during this period. Tennessee therefore in July 1982 increased coverage for the medically needy; they will now receive the same services as the categorically	

needy. At the same time, Tennessee reduced its medically needy eligibility population to only pregnant mothers and children under 21 in special groupings.

## **B. Utilization Controls**

- \* AL \*C /82 (-) Alabama is considering a lock-in of abusers of outpatient hospital services to one provider. Alabama currently has a limitation on non-emergency outpatient hospital visits of six per year; the purpose of this proposal would be to assist hospitals in avoiding nonpayment for services to overutilizers who have surpassed their visit limitation.
  
- \* CA \*A 5/82 (-) In California a \$1.00 copayment was imposed on most outpatient services provided to both categorically needy and medically needy, with the exception of children under 12 and women receiving prenatal services, children in foster care and persons in a hospital or nursing home. Copayments are collected by or obligated to the provider at the time the service is rendered. At the provider's option, the copayment amount may be waived. Any copayment collected is in addition to the usual program reimbursement. The program began May 1982 after California received an 1115 waiver.
  
- \* KS \*A 7/83 (+) Kansas began covering one outpatient sonogram per pregnancy (nine months). Medical necessity documentation is required for a subsequent sonogram per recipient per nine months.
  
- \* MA \*P /83 (-) Massachusetts is considering the imposition of a \$1 copayment for hospital outpatient department and emergency room services, with the exception of those services necessary for the preservation of life.
  
- MI \*C /82 (-) The State of Michigan is considering the imposition of a \$5.00 copayment on all non-emergency outpatient hospital visits.
  
- \* MO \*A 2/83 (-) Missouri implemented a \$3 hospital outpatient department copayment, with the exceptions listed in TEFRA. This \$3 includes a \$2 copayment for the outpatient department/emergency room services and a \$1 copayment for the physician services.



- NE \*A 5/82 (-) Nebraska began requiring prior authorization of outpatient psychotherapy services totalling more than \$500 per calendar year.
- NJ \*A 3/82 (-) New Jersey began requiring prior authorization for out-of-state non-emergency inpatient and outpatient hospital care.
- \* NC \*P /83 (-) North Carolina is proposing to alter its copayment structure by extending copayments to hospital outpatient services for the categorically needy. It also proposes to delete the copayment for inpatient hospital services for the medically needy; and to extend its physician copayment to the categorically needy while lowering the physician copayment from \$1 to \$.50 for all groups. The target date for these changes is April 1984.
- \* SC \*C /83 (-) South Carolina is developing a proposal for a voluntary ambulatory surgical program which would provide financial incentives for physicians to perform surgical procedures in the least costly appropriate setting. Reimbursement rates would rise for procedures which are performed, appropriately, in the physician's office and would also change for surgery performed in hospital outpatient clinics and ambulatory surgical centers. Inpatient hospital surgical rates would remain the same.
- \* SD \*A 7/83 (-) South Dakota imposed recipient cost-sharing of five percent of the total charge for non-emergency outpatient hospital services.
- \* SD \*A 7/83 (-) South Dakota imposed recipient cost-sharing for rehabilitation hospital services of \$25.00 for each inpatient admission and five percent of the total outpatient charge.
- VA \*A /82 (-) (HB 30) The Virginia legislature enacted a law which imposes a \$2 per visit copayment on non-emergency outpatient hospital services for the medically needy.

### C. Reimbursement

- CA \*A 8/82 (-) California reduced fees for physician and hospital outpatient services by ten percent. These reductions do not apply to clinics licensed pursuant to Chapter 1 of the California Health and Safety Code commencing

with Section 1200 (e.g., primary care clinics, free and community clinics, rural clinics).

- DC \*A 6/82 (-) The District of Columbia adopted a limitation of 109% of audited FY80 costs on reimbursement levels for hospital outpatient and emergency room services.
- \* FL \*A 7/83 (-) The Florida legislature decreased the ceiling for outpatient hospital services from \$500 to \$100 per individual per fiscal year.
- FL \*A 1/82 (-) The State of Florida changed to a prospective reimbursement system for outpatient hospital services.
- \* IL \*A 7/83 (-) As of July 1983, Illinois began reimbursing for hospital outpatient and clinic services on a fee-for-service basis. Reimbursement levels are at the lower of the hospital's usual and customary charge to the public or Medicaid's statewide maximum reimbursement screens. These screens are the same as those applied to non-hospital providers rendering the same services.

Some services, however, are considered "hospital outpatient unique" and are reimbursed on a higher, all-inclusive basis. There will be no year-end reconciliation for outpatient and clinic services. Renal dialysis services shall be paid for at Medicaid's standard all-inclusive rate.

Previously, hospital outpatient and clinic services were included with hospital inpatient services, and all three were reimbursed together using Illinois' alternate reimbursement methodology.

- IL \*A 1/82 (-) The State of Illinois established an alternative reimbursement methodology for hospital inpatient, outpatient, and clinic services, effective retroactively to October 1, 1981. To establish reimbursement rates for these services, the state first made an estimate of the utilization levels for these services for each hospital. After hospitals were given an opportunity to revise these estimates, each hospital's fiscal year 1979 cost per unit of service was updated to January 1, 1981 using a hospital inflation rate developed by Data Resources, Inc. (DRI). The DRI updating factors ranged from 29.7% for hospitals with fiscal years

ending in January 1979, to 20.1% for hospitals with fiscal years ending in December 1979.

The state then calculated expected spending for hospital services for October 1 through June 30 by multiplying each hospital's updated DRI figure by its estimated utilization and totaling the amounts for all hospitals. Because the DRI updated figures exceeded available funds, the figures were then reduced 14.27% for all hospitals. However, in order to provide special relief to hospitals serving a disproportionately high volume of Medicaid patients, the adjusted DRI figures were increased by an amount equal to 3% of the reduction for each percent of Medicaid utilization between 25% and 35% Medicaid, plus 1% for each 1% over 35% Medicaid. (For example, a hospital with 15% Medicaid utilization had its DRI figure reduced by 14.27%; a hospital with 35% Medicaid utilization had its DRI figure reduced by 10.60%; and a hospital with 50% Medicaid utilization had its DRI figure reduced by 8.77%.) If the final rate, calculated as described above, is less than or equal to a hospital's current rate, the hospital will be paid at this calculated rate for services rendered after September 30, 1981, and payable from the fiscal year 1982 appropriation. If a hospital's current payment rate is less than this calculated rate, the hospital will be paid at its current rate.

New hospitals or hospitals that have significantly restructured since their fiscal year 1979 may notify the state that they have restructured, submit supporting documentation (such as certificate of need) and request a rate review. These hospitals may have artificially low rates because the restructuring has not been taken into account by this updating methodology.

In addition to the above adjustments, hospitals that have a high percentage of government payors and that may suffer extreme financial hardship as a result of this rate methodology may request special consideration for potential, severe cash flow problems. To qualify, at least 65% of the hospital's total inpatient days must be reimbursed under Medicare, Medicaid, general assistance and aid to the medically indigent and at least 20% of the total inpatient days must be reimbursed by Medicaid. The hospital must submit its most recent



audited financial statement and any other financial and legal documents which would establish that the hospital has insufficient funds to meet its cash flow requirements, including a cash flow statement for July 1, 1981 through June 30, 1982. A \$6.5 million pool has been set aside to assist these hospitals, with the allocation of this amount among qualifying hospitals determined by a panel of hospital fiscal experts.

- \* KS \*P /83 (-) Kansas is working with the Kansas Hospital Association to develop a new reimbursement methodology for hospital outpatient services. The target date is May 1984.
- MA \*X 1/82 ( ) (S 635) The Massachusetts legislature reported that a resolution was introduced to require the Department of Public Welfare to study reimbursement alternatives for hospital outpatient services. This proposal has been dropped.
- MI \*A 9/82 (-) Michigan began reimbursing all outpatient hospital services on a fee-for-service basis, the lesser of charge or screen. (Estimated annual savings: \$6 million).
- \* NV \*C /83 (-) Nevada is considering an all-inclusive prospective rate for outpatient surgical procedures.
- \* NC \*A 7/83 (-) (SB 23) The North Carolina legislature enacted a law which limits hospital outpatient reimbursement to 80 percent of allowable costs.
- OH \*P /82 (-) Ohio is considering reimbursement of outpatient hospital services on a fee-for-service basis.
- \* OK \*A 4/83 ( ) In Oklahoma, provision was made for payment for a special category of "organized outpatient hospital clinic services" to eligible hospitals who have a contract with the department to provide such services.
- PA \*A 10/82 (+) In Pennsylvania the basic hospital outpatient clinic visit fee was increased from \$6 to \$10.
- RI \*A 4/82 (-) Rhode Island reduced reimbursement levels for hospital outpatient services from 100 percent to 90 percent of the reimbursable cost of such services as determined through application of the principles of Rhode Island's Prospective Hospital Reimbursement System. This rate of reimbursement will be applied to all hospital



clinic and emergency room visits, laboratory tests, x-rays and other services provided in the hospital outpatient department. However, it will not apply to the costs associated with provision of ambulatory surgery in a hospital outpatient department.

- SC \*A 3/82 (-) South Carolina lowered its reimbursement levels for hospital out-patient services by 46 percent, across the board. The state had originally proposed to alter reimbursement for these services by paying physician rates for services comparable to those delivered in physicians' offices. However, the hospital association took the state to court over this proposal as well as one to lower the hospital day limitation to 12 days per year. The state won the court suit. However, it negotiated with the hospital association and agreed to adopt the 46 percent reduction in lieu of reimbursement at physician rates.
- VA \*A /82 (+) (HB 30) The Virginia legislature enacted a law which increases reimbursement for hospital outpatient services from 90% to 100% of cost.
- WI \*P /83 (-) Wisconsin proposes to broaden, to apply to all outpatient services, its policy of limiting reimbursement (formerly applicable only for outpatient department lab and x-ray services) to rates comparable to that paid to independent providers of such services.

#### 4. Hospital Emergency Room Services

##### A. Amount, Duration and Scope

- IL \*A 7/82 (-) Illinois limited coverage of emergency room services to those necessary for relief of severe pain, immediate diagnosis and for conditions that would result in death or disability.
- MI \*A 1/82 (-) The State of Michigan no longer will cover non-emergency services rendered in a hospital emergency room.
- MO \*A 11/82 (-) Missouri limited emergency room and outpatient visits to two per month, with an exception for those outpatient visits that would otherwise be performed on an inpatient basis, i.e., chemotherapy visits. (The majority of hospitals in Missouri do not have distinct parts for the emergency room as separate from the outpatient clinic. Therefore, the limitation is for any combination of such visits in a calendar month.)
- MO \*X 3/82 (-) Missouri proposed to allow only one emergency room/outpatient hospital facility charge per recipient per day. This proposal was dropped.
- WV \*A 1/82 (-) West Virginia limited coverage of emergency room and associated ancillary services to conditions related to accident, injury or trauma.

##### B. Utilization Controls

- \* CA \*A 5/82 (-) California implemented a \$5.00 copayment on non-emergency care received in emergency rooms. Exempt from this copayment are children under 12 and women receiving prenatal services.
- Copayments are collected by or obligated to the provider at the time the service is rendered. At the provider's option, the copayment amount may be waived. Any copayment collected is in addition to the usual program reimbursement. The program began May 1982, after California received an 1115 waiver.
- CT \*X /82 (-) The State of Connecticut considered placing restrictions on emergency room use. These would have included a requirement for documentation of an emergency and a \$3.00 co-payment

for both categorically-related and medically-needy recipients. A federal waiver was needed in order to implement the co-payment provision. However, this is no longer being considered.

- \* MA \*P /83 (-) Massachusetts is considering the imposition of a \$1 copayment for hospital outpatient department and emergency room services, with the exception of those services necessary for the preservation of life.
- MI \*C /82 (-) The State of Michigan is considering the imposition of a \$5.00 copayment on all non-emergency outpatient hospital visits.
- \* MO \*C 1/84 (-) Missouri is considering establishing an emergency medical hotline to triage Medicaid patients in St. Louis City. Callers are asked to describe their problems and then providers are assigned.
- \* UT \*A /83 (-) The Utah legislature enacted a law requiring the selective implementation of patient cost-sharing. The Medicaid Agency is conducting an evaluation of the program and will present its recommendations to the legislature. It is considering a copayment on non-emergency services provided by hospital emergency rooms in order to encourage use of alternative types of ambulatory care.
- \* WA \*A 12/82 (+) The state of Washington rescinded the \$85 deductible per hospital admission and \$2 copayment per emergency room visit which it had been charging to medically needy and medically indigent recipients under its Limited Casualty Program (LCP).
- WA \*X /82 (-) Washington requested a freedom of choice waiver seeking to implement a \$5.00 copayment for emergency hospital and outpatient hospital visits for all Medicaid recipients, except residents of institutions. HCFA disapproved this request, stating that the legislative provision referenced provided no authority to approve waivers for copayments.

### C. Reimbursement

- \* DE \*P /83 (-) Delaware is proposing to pay emergency rooms at a lower rate for non-emergency services.
- DC \*A 6/82 (-) The District of Columbia adopted a limitation of 109% of audited FY80 costs on reimbursement levels for hospital outpatient and emergency room services.
- \* TX \*A 4/82 (-) Effective April 1982, Texas no longer pays for non-emergency services delivered in an emergency room. Emergencies must either be documented or identified by a trauma code.
- \* TX \*A 4/82 (-) Texas implemented a new policy that, if an individual is seen in a hospital emergency room on the same day that he is admitted to that hospital, the emergency room charges must be included in the hospital charges and cannot be billed separately.
- VT \*A 8/82 (-) Vermont ceased paying emergency room rates to emergency rooms for non-emergency services delivered at any time. (Previously, this was the case only between the hours of 8:00 am to 4:00 pm on weekdays). Non-emergencies are reimbursed at physician rates.
- WI \*A /82 (-) The State of Wisconsin began reimbursing for non-emergency care provided in hospital emergency rooms at the regular office visit rate.



## 5. Rural Health Clinic Services

### A. Amount, Duration and Scope

- \* KY \*A 6/82 (+) Kentucky implemented coverage of free-standing rural health clinic services.
- \* KY \*A 5/82 (+) Kentucky implemented coverage of provider-based rural health clinic services.
- MS \*A 11/82 (+) In Mississippi, the number of visits reimbursable for physician services rendered in a physician's office, outpatient department of a hospital, or rural health clinic is increased from 12 to 18 per fiscal year.
- NC \*A 7/82 (+) North Carolina increased from 18 to 24 the number of allowed visits to one or a combination of the following services: outpatient hospital departments (excluding emergency rooms); rural health clinics; physicians; clinics (except mental health centers); optometrists; podiatrists; and chiropractors. Exemptions from the limitation did not change.

### B. Utilization Controls

- NE \*X /82 (-) Nebraska considered requiring prior authorization of day care and partial hospitalization services. However, this proposal was dropped.

### C. Reimbursement

- \* AK \*A 7/83 (-) (SB 85) The Alaska legislature enacted a law which established the Medicaid Rate Commission to set prospective payment rates for all health facilities, including: hospitals, SNFs, ICFs, ICFs/MR, rehabilitation facilities, inpatient psychiatric facilities, home health agencies, rural health agencies, and outpatient surgical clinics.
- \* NC \*A 7/83 (-) (SB 23) The North Carolina legislature enacted a law which reimbursed rural health clinic services at reasonable cost for provider-based clinics and a single rate per visit for nonprovider-based clinics, subject to a 7 percent limit on rate increases.

## 6. Other Clinic Services

### A. Amount, Duration and Scope

- AK \*A 7/82 ( ) Alaska changed its definition of clinic services to include physician clinics, in addition to community mental health clinics. Many Indian health care clinics will fall within this category.
- FL \*A 2/82 (-) Florida added community mental health services as a reimbursable service under 42 CFR 440.90, Clinic Services. Only outpatient services will be covered under this program. This will provide a less expensive alternative for provisions of mental health services. (Contact: Art Williams 904/488-9228)
- \* HI \*A /83 (-) Hawaii has contracted with a birthing center, operated by a nurse practitioner, for provision of services to Medicaid recipients.
- \* IL \*A /83 (+) (H 308) The Illinois legislature enacted legislation to add diagnosis and treatment of sickle cell anemia.
- \* KS \*A 5/83 (-) Kansas modified its coverage of partial hospitalization services provided by Community Mental Health Centers. Certain services were dropped and those remaining were limited to 168 hours per calendar month per recipient.
- \* KS \*A 5/83 (-) Kansas limited outpatient psychotherapy rendered by a Community Mental Health Center to 200 units per calendar quarter.
- \* KS \*A 1/83 (-) Kansas ceased reimbursing Community Mental Health Centers for day treatment programs. The state now only reimburses for partial hospitalization programs.

Partial hospitalization is an ambulatory treatment approach that includes the major diagnostic, medical, psychiatric, psychosocial, and pre-vocational/educational treatment modalities typically found in a comprehensive psychiatric hospital program. It is designed for patients with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment not provided in an outpatient clinic setting. By offering a medically supervised alternative to inpatient treatment, it provides a more flexible and less restrictive form of treatment.

Therapeutic modalities typically offered in partial hospitalization programs include:

- A balance of various group and/or family therapies,
- Pharmacotherapy,
- Activity/recreational therapies,
- Socialization skills development in a structured therapeutic environment, and
- Integration/Reintegration services that are designed to help the patient remain in his/her community and function at the highest level of autonomy and independence as is realistically possible.

Partial hospitalization embraces day, evening, night, and weekend treatment programs that employ an integrated and comprehensive schedule of recognized psychiatric treatment. Programs will vary according to unique geographic and demographic characteristics of the communities being served, and, therefore, must be coordinated with hospital affiliations and community support networks.

Partial hospitalization services are utilized by individuals who are mentally or emotionally impaired, but who are able to maintain themselves in the community at a minimal level of functioning, and present no imminent potential for harm either to themselves or to others.

\* KS \*A 9/82 (+) Kansas added Community Mental Health Center emergency services provided in a general hospital emergency room if provided by a certified psychologist, master degreed psychologist, master degreed social worker or physician. This will be reimbursed as individual clinic therapy. A charge for the emergency room by the hospital will not be paid in conjunction with this procedure unless there is a medical or surgical emergency.

\* KY \*A /83 (+) Kentucky added coverage of services provided by alternative birth centers. These include pre-natal care, services and supplies related to delivery, a post-partum examination and a maximum of two post-natal visits within six weeks of delivery.



*	ME	*A	8/83 (+)	Maine added certain procedure codes for family therapy to Mental Health Clinic Services coverage. In addition, a special procedure code was added for use in those instances of psychiatric testing in which the recipient is legally blind/impaired.
	MA	*A	1/83 (-)	Massachusetts established regulations governing the operation of free-standing mental health centers.
	MA	*P	/83 ( )	(S. 1965) The Massachusetts legislature reports the introduction of a bill to provide up to 90 days of psychiatric day treatment.
	MI	*A	4/83 (+)	In cooperation with the Michigan Department of Mental Health, the Department of Social Services has received approval of two freedom of choice waiver requests to provide clinic-based mental health services under Title XIX, one to provide day treatment, and the other to expand outpatient care. The waivers allow reimbursement for services of non-physician personnel on a fee-for-service basis. Coverage is limited to services provided by Community Mental Health Services Boards throughout the state who are providing case management of mental health services for both mentally ill and mentally retarded patients. This statewide project is known as the Primary Mental Health Clinic Sponsor Program, or the Clinic Services Program.
	MI	*A	/82 (-)	The State of Michigan began limiting outpatient psychiatric treatments to 5 per year per recipient (with a physician) and 15 per year per recipient (with a psychiatrist). Previous policy allowed 5 and 10 visits respectively. Prior authorization is now required for any treatments beyond these limitations. A prior authorization subsystem is being developed to track the number of visits made by recipients.
*	MN	*A	/82 (-)	Minnesota froze, for all practitioners, the reimbursement rates to the July 1, 1979 profile levels. This covered 1982-1983.
	NJ	*A	/82 (-)	New Jersey began recognizing freestanding ambulatory surgical facilities for Medicaid reimbursement purposes.
	NC	*A	7/82 (+)	North Carolina increased from 18 to 24 the number of allowed visits to one or a combination of the following services: outpatient hospital departments (excluding



emergency rooms); rural health clinics; physicians; clinics (except mental health centers); optometrists; podiatrists; and chiropractors. Exemptions from the limitation did not change.

NC \*A 7/82 (+) North Carolina eliminated limits (previously 18 per year) on the number of visits allowed to mental health centers.

\* OH \*A 7/83 (-) (H 291) The Ohio legislature enacted a law which established outpatient health facilities as a separate provider category. An outpatient health facility is not an outpatient hospital facility, but provides comprehensive primary health services at least five days per week, is operated by a public or non-profit organization, and receives at least seventy-five percent of its revenues from public sources.

PA \*A 3/82 (-) Pennsylvania placed a limit on drug and alcohol abuse treatment clinic services of six hours of psychotherapy per patient per month.

PA \*A 3/82 (-) Pennsylvania modified its policy toward methadone maintenance clinic services. In January, 1980 it limited visits to these clinics to six per week for three calendar months, after which the limit was to be reduced to three visits per week. This policy was challenged in court and never implemented. However, effective March, 1982, a limit of one visit per day, seven days per week was imposed.

UT \*A /82 (-) Utah made a modification in its Clinic Services benefit: "clinics mental" were separated out from the "clinics special" category, as a sub-category. "Clinics special" include ESRDs, Ambulatory Surgical Centers, and day treatment for the mentally retarded. "Clinics mental" provide individual and group therapy, medication management and day treatment. The limitation on day treatment for clinics mental was reduced from 12 to 8 hours per day.

## **B. Utilization Controls**

- MI \*A /82 (-) The State of Michigan began limiting outpatient psychiatric treatments to 5 per year per recipient (with a physician) and 15 per year per recipient (with a psychiatrist). Previous policy allowed 5 and 10 visits respectively. Prior authorization is now required for any treatments beyond these limitations. A prior authorization subsystem is being developed to track the number of visits made by recipients.
- OR \*X /82 (-) Oregon considered the imposition of copayments on visits to clinics and hospital outpatient facilities, as well as to physicians. However, this was dropped.
- UT \*A 9/82 (-) Utah began requiring prior authorization for all day treatment provided by mental health clinics. It simultaneously dropped prior authorization for group therapy sessions (previously it was required for more than three group therapy sessions per week).
- VA \*A /82 (-) (HB 30) The Virginia legislature enacted a law which imposes a \$1 copayment on nonemergency clinic services for all recipients.

## **C. Reimbursement**

- \* AK \*A 7/83 (-) (SB 85) The Alaska legislature enacted a law which established the Medicaid Rate Commission to set prospective payment rates for all health facilities, including: hospitals, SNFs, ICFs, ICFs/MR, rehabilitation facilities, inpatient psychiatric facilities, home health agencies, rural health agencies, and outpatient surgical clinics.
- CA \*A 9/82 (-) California began reimbursing for mental health and drug services under the Short-Doyle program at the lower of reasonable costs or customary charges.
- IL \*A 1/82 (-) The State of Illinois established an alternative reimbursement methodology for hospital inpatient, outpatient, and clinic services, effective retroactively to October 1, 1981. To establish reimbursement rates for these services, the state first made an estimate of the utilization levels for these services for each hospital. After hospitals were given an opportunity to revise these estimates, each hospi-

tal's fiscal year 1979 cost per unit of service was updated to January 1, 1981 using a hospital inflation rate developed by Data Resources, Inc. (DRI). The DRI updating factors ranged from 29.7% for hospitals with fiscal years ending in January 1979, to 20.1% for hospitals with fiscal years ending in December 1979.

The state then calculated expected spending for hospital services for October 1 through June 30 by multiplying each hospital's updated DRI figure by its estimated utilization and totaling the amounts for all hospitals. Because the DRI updated figures exceeded available funds, the figures were then reduced 14.27% for all hospitals. However, in order to provide special relief to hospitals serving a disproportionately high volume of Medicaid patients, the adjusted DRI figures were increased by an amount equal to 3% of the reduction for each percent of Medicaid utilization between 25% and 35% Medicaid, plus 1% for each 1% over 35% Medicaid. (For example, a hospital with 15% Medicaid utilization had its DRI figure reduced by 14.27%; a hospital with 35% Medicaid utilization had its DRI figure reduced by 10.60%; and a hospital with 50% Medicaid utilization had its DRI figure reduced by 8.77%.) If the final rate, calculated as described above, is less than or equal to a hospital's current rate, the hospital will be paid at this calculated rate for services rendered after September 30, 1981, and payable from the fiscal year 1982 appropriation. If a hospital's current payment rate is less than this calculated rate, the hospital will be paid at its current rate.

New hospitals or hospitals that have significantly restructured since their fiscal year 1979 may notify the state that they have restructured, submit supporting documentation (such as certificate of need) and request a rate review. These hospitals may have artificially low rates because the restructuring has not been taken into account by this updating methodology.

In addition to the above adjustments, hospitals that have a high percentage of government payors and that may suffer extreme financial hardship as a result of this rate methodology may request special consideration for potential, severe cash flow problems. To qualify, at least 65% of the hospital's total inpatient



days must be reimbursed under Medicare, Medicaid, general assistance and aid to the medically indigent and at least 20% of the total inpatient days must be reimbursed by Medicaid. The hospital must submit its most recent audited financial statement and any other financial and legal documents which would establish that the hospital has insufficient funds to meet its cash flow requirements, including a cash flow statement for July 1, 1981 through June 30, 1982. A \$6.5 million pool has been set aside to assist these hospitals, with the allocation of this amount among qualifying hospitals determined by a panel of hospital fiscal experts.

- |    |    |             |   |
|----|----|-------------|---|
| KS | *A | 7/82 (-)    | Kansas set maximum reimbursement levels for geriatric, psychiatric, alcohol and drug day treatment and for psychiatric partial hospitalization. Future payment levels will increase by a negotiated inflation factor.   |
| KS | *A | 5/82 (-)    | Kansas limited reimbursement of Community Mental Health Centers to the 1981 cost report rates. Future payment levels will increase by a negotiated inflation factor.  |
| *  | KY | *A /83 (+)  | Kentucky added coverage of services provided by alternative birth centers. The level of reimbursement for services and supplies related to delivery will be the center's usual and customary fee, with a ceiling of \$350. Birth center employees' services will be reimbursed at the same rate as those of an individual practitioner providing the same services. |
| *  | KY | *A 7/82 (+) | The maximum reimbursement rate for dual-licensed pediatric facilities was removed. Reimbursement is now prospective, based on costs.  |
|    | KY | *A 7/82 (-) | The Community Mental Health Center reimbursement system was revised so that reimbursement would be based on units of service (time) instead of visits. Payment is based upon percent of charges. Maximum payment is limited to a ten percent increase over 1982 costs.  |
| *  | KY | *A 4/82 (+) | Kentucky increased its upper limit of reimbursement for dual-licensed pediatric facilities to \$62.21, up from \$55.00.   |



*	ME	*A	10/83 (+)	Maine increased the reimbursement level for V.D. Clinic Services.
*	NM	*A	6/83 (+)	(SF 1234) The Minnesota legislature enacted a law which adds community mental health centers.
*	MN	*A	/82 ( )	Minnesota began reimbursing mental health clinics on the basis of the individual in charge of the clinic (e.g., psychiatrist or psychologist).
*	NC	*A	7/83 (-)	(SB 23) The North Carolina legislature enacted a law which mandates reimbursement of ambulatory surgical centers at a negotiated rate.
*	OH	*A	7/83 (-)	(H 291) The Ohio legislature enacted a law which provides that outpatient health facilities be reimbursed prospectively, with rates to take into account historic expenses, kinds of services offered, and geographic location.

## 7. Physician Services

### A. Amount, Duration and Scope

- \* AL \*A 7/83 (-) Within a calendar year each Alabama Medicaid recipient is now limited to no more than a total of twelve physician visits in any combination of office, hospital outpatient, or nursing home settings. Visits counted under this quota will include, but not be limited to, visits for: prenatal care, postnatal care, family planning, second opinions, consultations, referrals, EPSDT referrals, immunizations, injections, psychotherapy, physical therapy and care by ophthalmologists for eye disease.

Physician hospital visits do not count toward this limit: recipients hospitalized are entitled to the physician visits that are medically necessary during the hospital days that are paid for by Alabama Medicaid.

Psychiatric evaluation or testing, psychotherapy visits, group therapy and family therapy visits are counted as part of the yearly quota of 12 visits for each recipient.

Ancillary services when performed by a physician, or under his supervision, can be billed by the physician without counting an office visit. (Example: drug injection, laboratory and x-ray.)

- \* AL \*A 4/83 (-) Alabama limited psychotherapy, group therapy and family therapy, when medically necessary, to twenty-four visits per recipient per calendar year. Psychiatric evaluation or testing, when medically necessary and given by a physician in person, is limited to one per calendar year.

- CA \*A 9/82 (-) The California legislature required the Director of the Department of Health Services to identify surgical and medical procedures which may be performed in an outpatient setting and to establish conditions designed to ensure that such procedures will be performed on an outpatient basis when appropriate. The Director is required to establish utilization controls on surgical or medical procedures performed on an outpatient basis to ensure the medical necessity of such procedures.

*	GA	*A	4/82 (+)	Georgia raised its limitation on coverage of physician inpatient hospital visits to coincide with the expansion of covered hospital days from 20 to 25. Physician visits made within the 25-day limit will be paid.
	IL	*A	/82 (-)	Illinois identified ten surgical procedures which can ordinarily be performed on an outpatient basis and began requiring that, when they are done on an inpatient basis, the physician must document medical necessity. The state conducts post-audit reviews of these cases.
*	KS	*A	5/83 (-)	Kansas limited physician office visits to six per calendar quarter per recipient. This is an absolute limit with no exceptions for medical necessity. The previous limit was three visits per month.
*	KS	*A	2/83 (-)	Kansas eliminated coverage of certain procedures performed by physicians (the procedures affected are known as "Not Otherwise Classified Codes"). Some exceptions may be made with prior authorization.
*	KY	*A	9/82 (-)	Kentucky ceased coverage of both inpatient hospital and inpatient physician services related to fifteen surgical procedures except when: a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital.
*	ME	*A	8/83 (+)	Maine added coverage of mini-laparotomy for sterilization when performed in the physician's office setting.
	MD	*A	7/82 (+)	Maryland initiated coverage of psychiatric day treatment services in acute general hospitals.
	MA	*P	2/82 (+)	(H 1772) The Massachusetts legislature reports that a bill has been introduced to provide primary care services to recipients in long term care facilities.
	MI	*A	1/82 (-)	Michigan has dropped coverage of certain surgical procedures when performed in an inpatient hospital setting. These will be covered only in an ambulatory setting. (Ambulatory setting includes out-patient hospital.)



MI	*A	/82 (-)	The State of Michigan began limiting outpatient psychiatric treatments to 5 per year per recipient (with a physician) and 15 per year per recipient (with a psychiatrist). Previous policy allowed 5 and 10 visits respectively. Prior authorization is now required for any treatments beyond these limitations. A prior authorization subsystem is being developed to track the number of visits made by recipients.
MS	*A	11/82 (+)	In Mississippi, the number of visits reimbursable for physician services rendered in a physician's office, outpatient department of a hospital, or rural health clinic is increased from 12 to 18 per fiscal year.
*	MO	*P 12/83 (-)	Missouri proposes to limit coverage of physicians' weekend inpatient hospital visits to those hospital admissions covered by Medicaid. Medicaid pays for weekend admissions only in emergencies or when surgery or delivery follows within 24 hours.
*	MO	*P 10/83 (-)	Missouri proposes to limit coverage of physicians' inpatient hospital visits to those inpatient hospital days covered under the PAS length of stay limits.
*	MO	*P 9/83 (-)	Missouri has proposed to limit physician office visits to one per day with provision for a Medical Necessity exception.
*	MO	*A 8/83 (-)	Missouri dropped its limitation of three physician visits per month per provider, in order to effect a dollar savings in the hospital program.
MO	*A	3/82 (-)	Missouri instructed providers to perform diagnostic work-ups on an outpatient basis to the extent possible. This was reinforced by PSRO and SURS review. Later, in December 1982, PSRO utilization reviews were dropped and the state took over all utilization review.
MO	*X	3/82 (-)	Missouri proposed to limit physician office visits to two per month, with exceptions allowed if the visit was documented on the medical necessity form and reviewed and approved by the Medicaid Medical Consultant. The intent of this provision was to limit recipient-initiated contact, not physician-ordered and medically necessary visits. The latter are encouraged. This proposal was, however, dropped.



MO	*A	/82 (-)	Missouri began enforcing new limitations on physician services: (1) a maximum of one new patient office visit per provider per recipient; and (b) a maximum of one established patient comprehensive visit per provider per year per recipient.
* NH	*A	7/83 (+)	New Hampshire raised its ceiling on physician outpatient services from 12 to 18 visits per recipient per fiscal year.
NC	*A	7/82 (+)	North Carolina increased from 18 to 24 the number of allowed visits to one or a combination of the following services: outpatient hospital departments (excluding emergency rooms); rural health clinics; physicians; clinics (except mental health centers); optometrists; podiatrists; and chiropractors. Exemptions from the limitation did not change.
OR	*A	8/82 (+)	Oregon changed its administrative procedures in order to claim FFP (federal financial participation) for hysterectomies on presterile individuals.
SC	*A	1/82 (-)	South Carolina lowered the limit on physician inpatient hospital visits from 18 to 12 per year.
SD	*X	/82 (-)	South Dakota considered placing a limitation on the number of physician visits allowed. The current criterion is medical necessity. However, this proposal has been dropped.
TN	*A	7/82 (+)	In July 1981 Tennessee had eliminated coverage of the following services for most medically needy recipients: inpatient and outpatient hospital services, physician and pharmacy services, prosthetic devices, and Christian Science sanatoria services. Among the medically needy groups still able to receive physician and pharmacy services were nursing home residents. A federal court later ruled that this discriminated by class (according to living arrangements), and required the state to retroactively pay for services denied to medically needy recipients during this period. Tennessee therefore in July 1982 increased coverage for the medically needy; they will now receive the same services as the categorically needy. At the same time, Tennessee reduced its medically needy eligibility population to only pregnant mothers and children under 21 in special groupings.

VA \*A 7/82 (-) Virginia limited coverage of physician visits to hospital patients to 21 days.

## B. Utilization Controls

- CA \*A 9/82 (-) The California legislature required the Director of the Department of Health Services to identify surgical and medical procedures which may be performed in an outpatient setting and to establish conditions designed to ensure that such procedures will be performed on an outpatient basis when appropriate. The Director is required to establish utilization controls on surgical or medical procedures performed on an outpatient basis to ensure the medical necessity of such procedures.
- CA \*X 2/82 (-) (SB 1517) The California legislature reports the introduction of a bill to require second opinions on elective surgeries. This proposal was dropped.
- CT \*A 11/82 (-) The Connecticut legislature enacted a law to require second opinions for certain elective surgeries. Public law 82-430 makes mandatory second opinions for: tonsillectomy, adenoidectomy, hysterectomy, hemorrhoidectomy, cholecystectomy, meniscectomy, submucous resection/rhinoplasty, excision of varicose veins, disc surgery spinal fusion, and dilation and curettage.
- CT \*X /82 (-) Connecticut considered a proposal to lock in high utilizers to one physician. Connecticut already has a pharmacy lock-in program. However, this proposal was later dropped.
- \* KS \*A 5/83 (-) Kansas added a co-payment of \$1.00 for all physician office visits, per date of service.
- LA \*P 1/83 (-) Louisiana proposes to implement prior authorization for certain elective surgical procedures.
- ME \*A 8/82 (-) Maine established a prior authorization requirement for services related to gastric bypass or gastroplasty surgery. It must now be shown that the recipient meets certain requirements relating to weight, nonsurgical weight loss efforts, and the existence of certain medical conditions.

\* MI \*P /83 (-) Michigan is considering a proposal to impose copayments on physician services.

MI \*X /82 (-) The State of Michigan considered expanding the list of elective surgeries for which second opinions are required. This proposal has been dropped.

MI \*A /82 (-) The State of Michigan began limiting outpatient psychiatric treatments to 5 per year per recipient (with a physician) and 15 per year per recipient (with a psychiatrist). Previous policy allowed 5 and 10 visits, respectively. Prior authorization is now required for any treatments beyond these limitations. A prior authorization subsystem is being developed to track the number of visits made by recipients.

\* MN \*P /83 (-) (HF 742): The Minnesota legislature reports introduction of a bill to require a second opinion for elective surgeries.

\* MO \*A 2/83 (-) Missouri implemented a \$3 hospital outpatient department copayment, with the exceptions listed in TEFRA. This \$3 includes a \$2 copayment for the outpatient department/emergency room services and a \$1 copayment for the physician services.

MO \*P 12/82 (-) Missouri proposes to establish Physician Peer Review Committees -- one for M.D.s and one for D.O.s.

MO \*P 2/82 (-) Missouri has proposed to develop computer edits to verify the medical necessity of physician and podiatrist procedures according to the diagnosis stated on the claims.

MO \*X 1/82 (-) (HB 1089) The Missouri legislature reported the introduction of a bill to require prior authorization for surgery. The proposal was later dropped.

MO \*P /82 (-) Missouri is considering expanding the number of surgical procedures requiring a second surgical opinion.



NJ	*A	4/82 (-)	New Jersey began requiring mandatory second opinions for certain elective surgical procedures. These include: hysterectomy, cholecystectomy, tonsillectomy and/or adenoidectomy, laminectomy, spinal fusion and hernia repair (with the exception of children 0-18 years, in most cases). (Contact: I. Fulton Erlichman, M.D., Chief, Bureau of Professional Technical Services 609/292-8157).
*	NC	*P /83 (-)	North Carolina is proposing to alter its copayment structure by extending copays to hospital outpatient services for the categorically needy. It also proposes to delete the copayment for physician and inpatient hospital services for the medically needy. The target date for these changes is January 1984.
	NC	*P 10/82 (-)	North Carolina proposed to institute recipient lock-ins for over-users of physicians' services.
*	OH	*P /83 (-)	Ohio is proposing to implement a physician lock-in program to restrict to one physician those recipients who over-utilize services.
*	OR	*A 7/83 (-)	Oregon established a physician lock-in program. Recipients who are identified as over-utilizing services will be restricted to one physician.
	OR	*X /82 (-)	Oregon considered the imposition of copayments on visits to clinics and hospital outpatient facilities, as well as to physicians. However, this was dropped.
*	SC	*P /83 (-)	South Carolina is proposing to impose a copayment on physician services.
*	SD	*A 7/83 (-)	South Dakota imposed recipient cost-sharing of \$1.00 for each physician service billed.
	TX	*A 9/82 (-)	Texas implemented a lock-in program for recipients overutilizing physician and/or pharmacy services. Overusers may be locked in to one physician, one pharmacy or both. The physician lock-in affects physician services in all settings, including office visits, outpatient care, and emergency room services.
	VA	*A /82 (-)	(HB 30) The Virginia legislature enacted a law which imposes a \$1 per visit copayment on physician services for the medically needy.



- WV \*X /82 (-) West Virginia requested a waiver in order to impose copayments for physician services. This proposal has been dropped.
- \* WI \*A 7/83 (-) (SB 83) The Wisconsin legislature passed a law to exempt from copay requirements the first two visits per month to a primary provider.
- \* WI \*A 5/83 (+) Wisconsin eliminated the requirement for a mandatory second opinion for transurethral restrictions (prostate) and for inguinal hernia repairs in children under age 5.
- WI \*A 6/82 (-) The Wisconsin legislature enacted legislation making permanent the requirement of a second opinion for certain surgical procedures. This was previously "sunset" legislation which required periodic renewal.

### C. Reimbursement

- CA \*A 9/82 (-) California reduced fees for acupuncture services by ten percent.
- CA \*A 8/82 (-) California reduced fees for physician and hospital outpatient services by ten percent. These reductions do not apply to clinics licensed pursuant to Chapter 1 of the California Health and Safety Code commencing with Section 1200 (e.g., primary care clinics, free and community clinics, rural clinics).
- DE \*P /83 (-) Delaware is proposing to lower its reimbursement rates for physician hospital visits.
- \* GA \*A 1/83 (-) In cases where specimens are analyzed free of charge by state-operated laboratories, Georgia limited physician reimbursement to only their collection and handling.
- \* GA \*A 1/83 (-) Georgia limited physician reimbursement to 65% of the maximum allowable payment for certain services rendered in a hospital setting which are commonly billed as an office service.
- \* GA \*A 11/82 (-) Georgia will no longer provide reimbursement to the operating surgeon for in-hospital preoperative visits prior to elective surgery, unless medically justified.

	HI	*P	/82 (-)	Hawaii is considering a proposal to adopt a fee schedule based on the HCPC procedural code system, with fixed dollar amounts for each procedure. This would be implemented in July 1984.
*	IA	*A	5/83 (-)	(HF 641) The Iowa legislature enacted a law which limited physician fee increases to 5 percent.
	IA	*A	7/82 (-)	The Iowa legislature adopted SF 2304, which changes the basis for physician reimbursement from area prevailing rates to statewide prevailing rates.
	IA	*A	7/82 (-)	The Iowa legislature enacted SF 2304, which limits physician fee increases to five percent a year.
*	KS	*A	7/83 (-)	Kansas increased reimbursement between eight and twenty percent for certain physician office visits, maternity services and procedures when performed in an outpatient setting.
*	KS	*A	4/83 (-)	Kansas began reimbursing physicians and hospitals for normal total OB deliveries at a higher rate if the mother is in the hospital 48 hours or less. Previously, the higher rate could only be paid if the mother stayed 24 hours or less.
*	KS	*A	12/82 (-)	Kansas ceased reimbursing physicians for office and hospital visits on the same day chemotherapy administration is performed.
	KS	*A	10/82 (-)	Kansas has increased reimbursement levels for selected physician services in an effort to provide incentives for reduced inpatient stays. Among those services are a number of procedures performed in the physician's office, such as office visits, in-office medical supplies and diagnostic and surgical procedures; and nursing home visits, emergency room visits and obstetrical services.
	KS	*A	2/82 (-)	Kansas eliminated payment to physicians for laboratory handling charges.
*	KS	*A	/82 (-)	Kansas began reimbursing for normal OB deliveries at a higher rate if the mother is in the hospital 24 hours or less.

*	ME	*A	/83 (+)	Maine raised fees for certain selected physician, dental, optometric and mental health services.
	MD	*A	7/82 (+)	Maryland increased its rates for nursing homes, laboratories, physicians, pharmacists, dentists, medical supplies and equipment, ambulances and wheelchair vans, and medical day care.
	MA	*A	7/82 (+)	In Massachusetts, as of July 1, 1982, the 15 percent reduction in fees (from the June 1975 level) for non-primary care services was removed. Medicaid now reimburses 100 percent of the Rate Setting Commission's approved amount for these services.
	MN	*A	2/82 (-)	The State of Minnesota has established a new screen within the payment process for physician services in that the 50th percentile of 1979 billings is set as the maximum payment. The federal upper limit established by Medicare at the 75th percentile is still effective if it is lower than the 50th percentile of 1979 service billings.
	MO	*A	12/82 (-)	Missouri increased fees for deliveries performed in the office (thereby decreasing cost and use of the inpatient/outpatient hospital).
*	MO	*A	12/82 (+)	Missouri added coverage of certain restricted surgical procedures in an office/clinic setting. Fees were assigned with the intent of creating incentives for performing these procedures in these settings.
	MO	*A	12/82 (+)	Missouri raised physician office fees.
	MO	*A	12/82 (-)	Missouri increased fees for evening office visits (thereby decreasing cost and use of the hospital emergency room).
	NE	*A	3/82 (-)	Nebraska has implemented its own system for establishing usual, customary, and prevailing Medicaid physician charges. This essentially replaces the state's previous physician fee schedules.
	NV	*C	/82 (-)	Nevada is considering a pilot project involving capitation payments to LTC facilities for all physician services provided to LTC patients.



- \* NC \*A 7/83 (-) (SB 23) The North Carolina legislature enacted a law which provided that there be no increase in fees of Physicians, Chiropractors, Podiatrists, Optometrists, and Dentists.
- NC \*A 10/82 (-) North Carolina adopted a physician fee schedule which uses the 75th percentile of charges in 1979 as the base. Primary care physicians will be paid 100% of the base for outpatient procedures, and 90% for non-surgical inpatient procedures. Specialists will be paid 90% of the base for all procedures, except inpatient surgical procedures. All physicians, regardless of specialty, will be paid the same inpatient surgical fee. The surgical fee will be set at 90% of the base for the specialty with the lowest base.
- \* OH \*A 4/84 (-) Ohio has initiated an outpatient and office surgery incentive program to encourage use of lower cost settings. Outpatient reimbursement will be increased by 20 percent and office visit payments increased by either \$25 or \$50 for a selected list of surgeries.
- \* OH \*A 10/83 (-) Ohio adopted provisions of TEFRA for compensating hospital-based physicians by requiring that they bill for services directly and their payment be limited to the maximum allowed under Medicare.
- \* OH \*C /83 (-) Ohio is considering an increase in physician fees for outpatient services as an incentive for the use of outpatient rather than inpatient care.
- OR \*A 3/82 (-) Oregon reduced fees for certain physician office visits.
- OR \*A 2/82 (-) Oregon reduced fees for selected surgical procedures to achieve a more equitable, relative value and reduce expenditures overall.
- OR \*A 2/82 (-) Oregon reduced surgical fees and anesthetist reimbursement by 10%.
- PA \*A 1/83 (+) Pennsylvania revised its physician fee schedule. It increased the maximum fees and made the fees for various services more compatible with each other.



- \* SC \*C /83 (-) South Carolina is developing a proposal for a voluntary ambulatory surgical program which would provide financial incentives for physicians to perform surgical procedures in the least costly appropriate setting. Reimbursement rates would rise for procedures which are performed, appropriately, in the physician's office and would also change for surgery performed in hospital outpatient clinics and ambulatory surgical centers. Inpatient hospital surgical rates would remain the same.
  
- SC \*A 7/82 (-) South Carolina implemented a physician payment (fee) schedule method of reimbursement effective July 1, 1982. Under this method, payment is calculated using the California Relative Value studies as a basis along with a conversion factor which will be determined annually based on budgetary constraints.
  
- SC \*A 2/82 (-) South Carolina reduced physician reimbursement by ten percent. It is calculated on a usual and customary or prevailing rate basis, and reimbursement is now at 90 percent of that amount.
  
- \* TN \*P 10/83 ( ) For a number of services and goods, including physician and dentist services, ambulance services, and supplies; Tennessee is proposing to upgrade its reimbursement rates (based on usual and customary charges), by changing its base year from CY1980 to CY1982. In 1982 the rates were not upgraded due to technical problems; in lieu of upgrading, the state raised its rates from 90 percent to 95 percent of reasonable charges. Therefore, when the rates are upgraded, it is anticipated that the percentage will be lowered.
  
- TN \*A 1/82 (-) Tennessee began reimbursing physicians at the rate for service when it was delivered, not billed.
  
- TN \*A /82 (+) Tennessee raised its physician reimbursement rates from 90 percent to 95 percent of the 1980 physician profiles. This action was taken in lieu of an upgrading of rates (i.e., a change from the base year to CY 1981) which was not undertaken due to technical difficulties.

WA \*A 1/82 (+) The State of Washington provided enhanced levels of reimbursement for primary care physician services, to include office and nursing home visits, obstetrical care and EPSDT services.

WI \*A /83 (-) The State of Wisconsin began reimbursing, at the outpatient rate, certain inpatient procedures which could have been performed on an outpatient basis. This is being phased in, by procedure, in 1983.

## 8. Nurse Practitioner or Midwife, Physician Extender Services

### A. Amount, Duration and Scope

*	AL	*A	7/82 (-)	Alabama began covering nurse-midwife services provided by registered nurses licensed as midwives. Delivery must be in a licensed hospital and work must be supervised by or associated with a physician.
	CT	*X	/82 (-)	The state of Connecticut considered regulations to provide coverage of nurse practitioner services. However, this proposal was dropped.
	DE	*A	7/82 (-)	Delaware added nurse-midwife services.
*	GA	*A	11/82 (-)	Georgia added nurse-midwife services.
	HI	*P	2/82 (-)	(SB 2358-82) The Hawaii legislature reports introduction of a bill to allow reimbursement for nurse-midwives.
*	KY	*A	7/83 (+)	Kentucky added coverage of nurse-midwives.
*	KY	*A	7/83 (+)	Kentucky added coverage of nurse-anesthetists.
*	ME	*A	1/84 (+)	Maine added nurse-midwife services.
	MA	*A	7/82 (+)	Effective July 1982, Massachusetts has added coverage for Certified Nurse-Midwives for obstetrical services limited to prenatal care, deliveries and postpartum care.
	MA	*P	1/82 ( )	(S 486) The Massachusetts legislature reported that a bill has been introduced to allow nurse practitioners to provide care in nursing homes and home care settings.
*	MN	*P	/83 (+)	(SF 216) The Minnesota legislature reports introduction of a bill to cover nurse practitioner services.
*	NH	*A	1/83 (+)	New Hampshire began allowing nurse-midwives to enroll in the Medicaid program and submit claims independently.
	NJ	*A	1/83 (-)	New Jersey began recognizing nurse-midwives as independent Medicaid providers. They will be reimbursed on a fee-for-service basis.
*	NM	*A	6/83 (+)	New Mexico added coverage of nurse-midwife services.

- OR \*A 5/82 (-) Oregon set a limit of once in two years on routine nurse practitioner exams administered primarily to determine visual acuity.
- \* TN \*A /83 ( ) The Tennessee legislature passed a law allowing physician assistants who meet the specified educational criteria to conduct community health clinics (without an R.N. present) under the written protocol of a physician.

## B. Utilization Controls

## C. Reimbursement

- KS \*A 7/82 (-) Kansas began reimbursing physicians for the services of physician extenders in their employ at the level of 75 percent of the physician rate.
- OR \*A 3/82 (-) Oregon reduced fees for higher level, nurse practitioner visits to match fees for mid-range level visits in order to control "creep" in billing higher level codes. (Fees for nurse practitioner services are 80% of physician fees for the same medicine and surgery procedures, and 100% of physician fees for lab and x-ray services.)
- PA \*A 10/82 (-) Pennsylvania began directly reimbursing midwives for their services, making them the only paraprofessionals to be paid directly by the state.
- SC \*A 7/82 (-) In South Carolina reimbursement for midwife services was modified. They are now paid a specific percentage of the fees established for physicians in the physician fee schedule. They previously received a percentage of physicians' usual and customary charges.



## 9. Optometrist Services

### A. Amount, Duration and Scope

- CA \*A 9/82 (-) The California legislature limited vision care services to those which are necessary to determine whether a condition may be present which, if left untreated, could lead to significant disability or threaten the life of the patient or other persons. If this criteria is met, necessary diagnostic and supplementary services may be authorized by the Department. Beneficiaries 21 years of age and older having vision complaints will be able to obtain an abbreviated eye examination which will determine whether a more complete examination is necessary. Additional services will be covered for patients with (1) a possible medical condition requiring differential diagnosis or treatment, (2) double vision, or (3) visual acuity of 20/40 or worse in the worst eye. Some beneficiaries with blurred vision below this acuity standard or eyestrain due to nonmedical conditions will not be entitled to full refractive examinations. Services explicitly deleted are optical devices used for ocular exercises, visual/vision training, and orthoptics. The Department anticipates that approximately 50 percent of adult eye examinations will be replaced by vision screening examinations at the intermediate service level.
- \* HI \*A 11/83 (-) Hawaii is instituting coverage of and separate reimbursement for visual screening. Visual screening is a preliminary examination to determine whether a full visual examination is needed. When a full visual exam is deemed unnecessary, reimbursement for the visual screening is one-half that of a full exam. When a screening leads to an exam, only the full examination is paid for.
- \* KS \*A 9/83 (+) Kansas added coverage of secondary intra-ocular lens implants.

- \* KS \*A 5/83 (-) Kansas reduced coverage of eye examinations and eyeglasses to one every four years. As before, exceptions to the eye exam limitation include EPSDT participants and those with medical conditions requiring more frequent exams by an ophthalmologist. EPSDT participants may receive eyeglasses more frequently; however, the second and subsequent pairs within four years must be pre-authorized. In addition, eyeglasses are covered for recipients within one year of cataract surgery.
  
- \* ME \*A 12/83 (+) Maine added three new procedure codes to its coverage of optometric services.
  
- \* MD \*A 1/83 ( ) Maryland reorganized its vision care regulations, separating out those exceptional services pertaining only to individuals under 21, and including them with the EPSDT regulations. Since non-EPSDT recipients may undergo visual examinations only once every two years and EPSDT recipients once a year, it was established that any person under 21 who is seeking an exam more than one year but less than two years from his previous exam must first receive a vision screening to ascertain whether an exam is needed. It was also determined that optometrists may provide vision screening services, although they will not be reimbursed for providing the examinations.
  
- \* MN \*A /83 (+) The Minnesota legislature added vision care and Medicare-certified rehabilitation agency services to its General Assistance Medical Care Program (GAMP), a state-only funded program.
  
- MO \*X 3/82 (-) Missouri proposed to allow one eye examination per year with no exceptions. This proposal was dropped.
  
- NC \*A 7/82 (+) North Carolina increased from 18 to 24 the number of allowed visits to one or a combination of the following services: outpatient hospital departments (excluding emergency rooms); rural health clinics; physicians; clinics (except mental health centers); optometrists; podiatrists; and chiropractors. Exemptions from the limitation did not change.
  
- OR \*A 5/82 (-) Oregon limited routine optometric exams administered primarily to determine visual acuity to once in two years.

RI \*A 5/82 (-) Rhode Island eliminated payment for optometry services (with the exception of eye examinations, refractions) for medically needy only recipients.

SC \*A 2/82 (-) South Carolina implemented a limitation of one vision examination per recipient per provider within a 12-month period.

VA \*A 7/82 (-) Virginia discontinued coverage of optometric services, with the exception of eye examinations.

#### B. Utilization Controls

\* KS \*A 5/83 (-) Kansas increased the copayment from \$.50 to \$1.00 for the following services:

Psychologist services (per visit, per date of service);

Chiropractic services (per visit, per date of service);

Dental services (per visit, per date of service);

Optometric services (per visit, per date of service), and

Pharmacy services (per prescription, new and refill).

\* MI \*A 7/83 (-) (HB 4558) Michigan's Appropriations Act requires the Department of Social Services to impose copayments on dental, podiatric, vision, chiropractic and hearing aid services for recipients over 21 years of age.

\* SD \*A 7/83 (-) South Dakota imposed recipient cost-sharing for optometric and optical services of \$1.00 for each procedure, \$1.00 for each lens charge, \$1.00 for each frame charge, \$1.00 for other parts, and \$1.00 for repair service. (EPSDT recipients 18 years and older are subject to this copayment.)

VA \*A /82 (-) The Virginia legislature enacted HB 30, which imposes a \$1 copayment for eye examinations on the medically needy and all other recipients over 21.

- \* WI \*A 7/83 (-) Wisconsin began requiring second opinions for cataract extractions done in conjunction with intra-ocular lens implants.

### C. Reimbursement

- KS \*A 3/82 (+) Kansas increased its reimbursement levels for certain ophthalmic materials.
- \* ME \*A /83 (+) Maine raised fees for certain selected physician, dental, optometric and mental health services.
- \* NC \*A 7/83 (-) (SB 23) The North Carolina legislature enacted a law which provided that there be no increase in fees of Physicians, Chiropractors, Podiatrists, Optometrists, and Dentists.
- NC \*A 10/82 (-) North Carolina adopted fee schedules for optometrists. These rates use the 75th percentile of charges in 1979 as the base.
- ND \*C 6/82 (-) North Dakota is considering a competitive bidding process for the purchase of eyeglasses.
- SC \*A 2/82 (-) South Carolina adopted fee schedules for dental care, vision care and durable medical equipment. The previous method of reimbursement was fee-for-service at usual and customary rates.



## 10. Dental Services

### A. Amount, Duration and Scope

- |    |    |              |  |
|----|----|--------------|--|
| AR | *A | 3/82 (+)     | Arkansas reinstated adult dental coverage for relief of pain only.   |
| CA | *X | 7/82 (-)     | California proposed limiting Medi-Cal dental benefits provided for beneficiaries age 21 and older to emergency services, dentures, and repair of dentures. This proposal was dropped.  |
| *  | GA | *A 12/82 ( ) | Georgia reinstated coverage of dentists' hospital time.  |
| *  | GA | *A 5/82 (+)  | Georgia added coverage of applications of Stannous Fluoride (2 per year per recipient).  |
| *  | GA | *A 5/82 (+)  | Georgia reinstated coverage of oral dental examinations (2 per recipient per calendar year) and management time for difficult children.  |
| *  | IL | *A 7/83 (-)  | Illinois limited dental coverage to emergencies and/or relief of pain and infection for three groups: General Assistance recipients, Medically Indigent recipients, and non-pregnant medically needy AFDC adults.  |
| *  | KS | *A 7/83 ( )  | Kansas has modified its dental program, including more limitations, a greater emphasis on prevention, and a raise in reimbursement levels. Some of the changes: <ul style="list-style-type: none"><li>● The calendar year maximum on certain procedure codes (above which prior authorization must be obtained) was raised from \$300 to \$500.</li><li>● Coverage of prophylaxis for adults was added.</li><li>● Prior authorization criteria for orthodontic treatment (covered for EPSDT only) and for dentures is more restrictive.</li><li>● Medical necessity documentation is no longer required to be attached to claims but should be documented in the patient's file.</li></ul> |

- Reimbursement has been raised from the 50th percentile of 1976 charges to the 75th percentile based on calendar year 1981 for all charges except dentures and orthodontics, which did not change.

	KS	*A	1/82 (+)	Kansas added coverage of stainless steel crowns and annual dental exams for its adult population.
*	KY	*A	11/82 (+)	In Kentucky, prosthetic and orthodontic coverage was reinstituted for recipients under age 21, retroactive to January 1, 1982. This includes all previously covered procedures in these two categories except complete dentures and full mouth braces (coverage had been deleted in January 1982).
	KY	*A	1/82 (-)	Kentucky eliminated coverage of orthodontics procedures for individuals 21 and under. (Contact: Anita Crask 502/564-5560)
	KY	*A	1/82 (-)	Kentucky eliminated coverage of mileage charges billed by dentists in connection with services provided to individuals 21 and under.
	KY	*A	1/82 (-)	Kentucky limited full mouth radiographs to one (1) every two (2) years per patient per dentist for individuals 21 and under.
	KY	*A	1/82 (-)	Kentucky limited bitewing x-rays to four (4) per patient per year per dentist for individuals 21 and under.
	KY	*A	1/82 (+)	Kentucky reinstituted coverage of diagnostic dental services for adults.
	KY	*A	1/82 (-)	Kentucky eliminated coverage of stannous fluoride and dental sealant as an option to second fluoride treatment for patients under 21. Dental prophylaxis limited to one (1) per year for patients under 21.
*	LA	*P	/83 (-)	Louisiana proposes to eliminate the adult dental program.

- \* ME \*A 11/83 (-) Maine has reorganized its dental services policies and added several new procedure codes which are designed to offer additional preventative services and expanded restorative and surgical procedures. Streamlining of dental policy for use with the computer billing and surveillance review systems should lead to more efficient and informative periodic reviews.
- \* MD \*A 1/83 (-) Maryland revamped and revised its Medicaid dental regulations. It separated out all exceptional regulations pertaining specifically to recipients under 21 and transferred them to the EPSDT program. The remaining regulations, for adults 21 years and older, were revised as follows:
- complete radiographic surveys and the full series of x-rays of the mouth are limited in frequency to no more than once every three years (exception: for traumatic injuries, a maximum of four panoramic radiographs will be covered);
  - all root canal therapies and apicoectomies must receive prior authorization (previously prior authorization was required only when more than one root canal procedure was performed at a time);
  - Dentures which are lost, stolen or broken will not be replaced prior to one year from placement, and rebasing will be included in the six months of aftercare and no more than once every two years thereafter.
- MD \*A 2/82 (+) Maryland began coverage of orthodontic services for participants in the EPSDT program who have a handicapping malocclusion.
- \* MO \*A 2/83 (-) Missouri began disallowing payment for denture relines and denture duplication when either or both services occur within 12 months of placement of the original denture.
- MO \*A 5/82 (+) Missouri eliminated previous limitations on certain procedures performed by oral surgeons.
- NJ \*A 2/83 (-) New Jersey limited dental examinations for adults 18 and over to once a year. Previously, the limit was once every six months for all ages, and it remains so for children 17 and



under. Additionally, fluoride treatments for individuals 18-20 have been limited to one a year. The previous limit was one every six months for everyone under 21, and it remains so for children 17 and under.

- \* OR \*A 11/83 (+) Oregon removed prior authorization requirements for most EPSDT dental care. In addition, it increased the allowed frequency for dental screens after the age of five years from one every three years to one per year.
- OR \*A 7/82 (-) Oregon repealed the \$100-per-month ceiling on emergency dental care services.
- RI \*A 5/82 (-) Rhode Island eliminated coverage of certain dental services, including bridgework, root canal therapy for bicuspid and molars, jacket crowns (except for fractured teeth), and extensive periodontal surgery and orthognathic surgery. (In the past, orthognathic and extensive periodontal surgery have been covered on an individual consideration basis only).
- RI \*A 5/82 (-) Rhode Island began limiting the provision of orthodontic treatment to eligible recipients under the age of 21 who are participating in the EPSDT Program. (Orthodontic treatment is provided only in those cases which represent severe dental deformity and/or marked functional impairment.) (Contact: Anthony Barile 401/464-2174)
- SC \*A 10/82 (-) South Carolina deleted coverage of indirect pulp caps and application of desensitizing medicaments.
- SC \*A 7/82 (-) South Carolina limited to 3 the number of covered emergency dental examinations per recipient within a 12-month period.
- SC \*A 7/82 (+) South Carolina reinstated coverage of root canal therapy and tooth replantation.
- TX \*A 7/82 (+) Texas reinstated a number of EPSDT dental services which were dropped in 1979. This action is in response to litigation which followed the reduction in services and which the state lost. Coverage of dental examinations was expanded to include one per year. In addition, the department reinstated certain procedure codes to the list of allowable services.



WV \*A 1/82 (-) West Virginia eliminated coverage of all dental services for recipients over 21 years of age.

WI \*A 8/82 (-) The State of Wisconsin limited its coverage of dental services by:

- eliminating certain dental procedures if equally effective alternative procedures are covered (e.g., eliminating gold crowns, but continuing to cover stainless steel and plastic crowns);
- placing frequency limitations on certain procedures (e.g., limiting recipients 13 and older to one oral examination in a 12-month period);
- placing age limitations on certain dental services (e.g., limiting fluoride treatments to recipients 12 and under); and
- requiring prior authorization for certain dental services.

WI \*X 2/82 (-) Wisconsin requested a federal waiver to replace its current comprehensive dental benefit with a major/catastrophic dental benefit involving a deductible and coinsurance feature. The state would continue its present dental coverage for EPSDT-screened children and the elderly and disabled in nursing homes. (Anticipated annual savings: \$7 million.) This proposal was dropped.

## **B. Utilization Controls**

CA \*P /83 (-) California proposes to expand prior authorization of dental services to approximately 85% of all procedures.

\* GA \*A 11/82 (+) Georgia removed the requirement for recipient copayments under the dental program.

IA \*A 4/82 (-) Iowa increased its copayment on dental services from \$1.00 to \$3.00 for total covered service rendered on a given date.

\* KS \*A 7/83 ( ) Kansas has modified its dental program, including more limitations, a greater emphasis on prevention, and a raise in reimbursement levels. Some of the changes:

- The calendar year maximum on certain procedure codes (above which prior authorization must be obtained) was raised from \$300 to \$500.
- Coverage of prophylaxis for adults was added.
- Prior authorization criteria for orthodontic treatment (covered for EPSDT only) and for dentures is more restrictive.
- Medical necessity documentation is no longer required to be attached to claims but should be documented in the patient's file.
- Reimbursement has been raised from the 50th percentile of 1976 charges to the 75th percentile based on calendar year 1981 for all charges except dentures and orthodontics, which did not change.

\* KS \*A 5/83 (-) Kansas increased the copayment from \$.50 to \$1.00 for the following services:

Psychologist services (per visit, per date of service);

Chiropractic services (per visit, per date of service);

Dental services (per visit, per date of service);

Optometric services (per visit, per date of service), and

Pharmacy services (per prescription, new and refill).

MA \*A 7/82 (-) Massachusetts streamlined the dental prior authorization process and instituted uniform criteria for making decisions.

\* MI \*A 7/83 (-) (HB 4558) Michigan's Appropriations Act requires the Department of Social Services to impose copayments on dental, podiatric, vision, chiropractic and hearing aid services for recipients over 21 years of age.

\* MS \*A 11/82 (+) Mississippi eliminated its \$2 copayment on non-EPSDT dental visits.

*	MO	*A	2/83 (-)	Missouri implemented an audit to restrict pulpotomy and apicoectomy procedures.
*	MO	*A	2/83 (-)	Missouri established an audit to limit procedures to the same tooth on the same date (e.g., root canal, apicoectomy).
*	MO	*A	2/83 (-)	Missouri established coinsurance on all dentures in lieu of the copayments previously charged (copayments were charged on dentures, beginning in November 1981). This change was made in order to match the maximum federal allowable cost-sharing on dentures.
	MO	*X	/83 (+)	Missouri has considered a proposal by the Dental Subcommittee to discontinue prior authorization of all dental services provided in a nursing home except for provision of dentures. However, this proposal was dropped.
	NE	*A	/82 (+)	Nebraska modified its prior authorization requirements for dental services. Any non-emergency services costing more than \$100 now must be pre-authorized. Previously, services costing more than \$40 required local pre-authorization; those over \$200, state pre-authorization. An earlier proposal to set the limit for pre-authorization at \$60 was dropped.
*	NM	*A	7/83 (+)	New Mexico eliminated its copayment on dental services.
*	OR	*A	11/83 (+)	Oregon removed prior authorization requirements for most EPSDT dental care. In addition, it increased the allowed frequency for dental screens after the age of five years from one every three years to one per year.
*	SD	*A	7/83 (-)	South Dakota imposed, under its dental program, recipient cost-sharing as follows: \$1.00 for tooth extractions, \$1.00 for dental surgical procedures, \$1.00 for setting of fractures, \$3.00 for full dentures, and \$3.00 for relining of dentures.
	VA	*A	/82 (-)	The Virginia legislature enacted HB 30, which imposes a \$1 copayment for dental exams, except those which are a result of EPSDT screening.
	WA	*P	/82 (-)	The State of Washington has proposed to establish a peer review process with the Washington State Dental Association.

WI \*A 8/82 (-) The State of Wisconsin limited its coverage of dental services by:

- eliminating certain dental procedures if equally effective alternative procedures are covered (e.g., eliminating gold crowns, but continuing to cover stainless steel and plastic crowns);
- placing frequency limitations on certain procedures (e.g., limiting recipients 13 and older to one oral examination in a 12-month period);
- placing age limitations on certain dental services (e.g., limiting fluoride treatments to recipients 12 and under); and
- requiring prior authorization for certain dental services.

### C. Reimbursement

CA \*A 8/82 (-) California reduced fees for dental services by 11.45% in FY 1982-83.

\* KS \*A 7/83 ( ) Kansas has modified its dental program, including more limitations, a greater emphasis on prevention, and a raise in reimbursement levels. Some of the changes:

- The calendar year maximum on certain procedure codes (above which prior authorization must be obtained) was raised from \$300 to \$500.
- Coverage of prophylaxis for adults was added.
- Prior authorization criteria for orthodontic treatment (covered for EPSDT only) and for dentures is more restrictive.
- Medical necessity documentation is no longer required to be attached to claims but should be documented in the patient's file.



- Reimbursement has been raised from the 50th percentile of 1976 charges to the 75th percentile based on calendar year 1981 for all charges, except dentures and orthodontics, which did not change.
- \* ME \*A 8/83 (+) Maine increased payment amounts and added new procedure codes for several dental services.
- ME \*A 1/83 (+) On January 1, 1983, Maine effected an overall increase of four percent in maximum allowances for most general dental procedures and extractions, and between five percent and 38 percent increases for certain prophylactic and restorative services allowances.
- ME \*A 1/82 (+) The state of Maine increased its fees for general dental procedures and extractions by approximately 9 percent, overall. It also increased its allowances for six prophylactic and restorative services by between 11 percent and 26 percent. This reflects an increase in the maximum allowances for most general dental procedures.
- MD \*A 7/82 (+) Maryland increased its rates for nursing homes, laboratories, physicians, pharmacists, dentists, medical supplies and equipment, ambulances and wheelchair vans, and medical day care.
- MS \*A 7/82 (+) Mississippi increased fees for dental services by 7.8%.
- NJ \*A 1/82 (-) The State of New Jersey changed its approach to reimbursing for dental services provided in hospital outpatient departments from a per visit charge to a fee-for-service basis identical to that which applies to dentists practicing independently. (Contact Archie Bell, D.D.S., Chief, Bureau of Dental Services 609/984-7863)
- \* NC \*A 7/83 (-) (SB 23) The North Carolina legislature enacted a law which provided that there be no increase in fees of Physicians, Chiropractors, Podiatrists, Optometrists, and Dentists.
- NC \*A 10/82 (-) North Carolina adopted fee schedules for dentists. These rates use the 75th percentile of charges in 1979 as the base.

- SC \*A 2/82 (-) South Carolina adopted fee schedules for dental care, vision care and durable medical equipment. The previous method of reimbursement was fee-for-service at usual and customary rates.
- \* TN \*P 10/83 ( ) For a number of services and goods, including physician and dentist services, ambulance services, and supplies, Tennessee is proposing to upgrade its reimbursement rates (based on usual and customary charges) by changing its base year from CY1980 to CY1982. In 1982 the rates were not upgraded due to technical problems; in lieu of upgrading, the state raised its rates from 90 percent to 95 percent of reasonable charges. Therefore, when the rates are upgraded, it is anticipated that the percentage will be lowered.

## 11. Podiatrist Services

### A. Amount, Duration and Scope

*	GA	*A	11/82 (+)	Georgia removed the copayment from the Podiatry Program.
	ID	*X	2/83 (-)	Idaho proposed to eliminate podiatric services. However, this proposal was dropped.
	IL	*A	6/82 (-)	Illinois dropped coverage of podiatric services for the non-pregnant adult AFDC medically needy, general assistance, and aid to the medically indigent recipients.
*	KS	*A	5/83 (-)	Kansas began limiting office visits for most podiatric services to two per month.
*	LA	*P	/83 (-)	Louisiana proposes to eliminate podiatric services.
	LA	*A	5/82 (-)	Louisiana limited its coverage of podiatric services to three services per recipient per calendar year. The term 'services' refers to individual procedures, more than one of which may be provided to a recipient in one visit.
*	MI	*X	/83 (-)	Michigan considered a proposal to eliminate podiatric services. However, this proposal was dropped.
	MO	*P	3/82 (-)	Missouri has proposed to limit podiatric office visits to two per month, with exceptions allowed if the visit is documented on the Medical Necessity Form and reviewed and approved by the Medicaid Medical Consultant.
	NC	*A	7/82 (+)	North Carolina increased from 18 to 24 the number of allowed visits to one or a combination of the following services: outpatient hospital departments (excluding emergency rooms); rural health clinics; physicians; clinics (except mental health centers); optometrists; podiatrists; and chiropractors. Exemptions from the limitation did not change.
	OR	*A	7/82 (-)	Oregon limited coverage of podiatrists' services to those provided in bona fide medical emergencies.
	PA	*A	8/82 (+)	Pennsylvania began coverage of two procedures for the debridement and treatment of mycotic nails.

PA	*A	8/82 (+)	Pennsylvania extended coverage of podiatrists' services compensable to all medically needy recipients.
PA	*A	8/82 (-)	Pennsylvania eliminated coverage of podiatrists' services as compensable for all State Blind Pension recipients.
RI	*A	5/82 (-)	Rhode Island eliminated payment for podiatry services for medically needy only recipients.
TN	*A	7/82 (+)	In July 1981 Tennessee had eliminated coverage of the following services for most medically needy recipients: inpatient and outpatient hospital services, physician and pharmacy services, prosthetic devices, and Christian Science sanatoria services. Among the medically needy groups still able to receive physician and pharmacy services were nursing home residents. A federal court later ruled that this discriminated by class (according to living arrangements), and required the state to retroactively pay for services denied to medically needy recipients during this period. Tennessee therefore in July 1982 increased coverage for the medically needy; they will now receive the same services as the categorically needy. At the same time, Tennessee reduced its medically needy eligibility population to only pregnant mothers and children under 21 in special groupings.
VA	*A	7/82 (-)	Virginia discontinued coverage of podiatry services.
WI	*X	2/82 (+)	(AB 1032) The Wisconsin legislature reported the introduction of a bill to restore coverage of podiatrist services for the categorically and medically needy. This proposal was dropped.

#### B. Utilization Controls



- CA \*A 9/82 (-) The California legislature added prior authorization to podiatric services. All podiatric services, no matter where they are performed, now require prior authorization except for documented emergency services and initial or minimal office or clinic visits which may be billed with MEDI labels (two per month). Emergency podiatric services require authorization on a retroactive basis. Podiatric services now are covered only to treat disorders of the feet secondary to or complicating a chronic disease and which significantly impair the ability to walk.
- IA \*A 4/82 (-) Iowa instituted a \$1.00 copayment on podiatrists' services for total covered service rendered on a given date.
- \* MI \*A 7/83 (-) (HB 4558) Michigan's Appropriations Act requires the Department of Social Services to impose copays on dental, podiatric, vision, chiropractic and hearing aid services for recipients over 21 years of age.
- MI \*A 1/82 (-) The State of Michigan implemented a \$2.00 copayment on podiatric services for Title XIX recipients 21 and older and for all General Assistance recipients.
- MO \*P 2/82 (-) Missouri has proposed to develop computer edits to verify the medical necessity, according to the diagnosis stated on the claims, of procedures performed by physicians and podiatrists.

### C. Reimbursement

- CA \*A 10/82 (-) Fees for podiatric services in California have been reduced by 10 percent.
- \* KS \*A 4/83 (-) Kansas effected an across-the-board ten percent reduction in reimbursement range maximums for podiatric services.
- \* NC \*A 7/83 (-) (SB 23) The North Carolina legislature enacted a law which provided that there be no increase in fees of Physicians, Chiropractors, Podiatrists, Optometrists, and Dentists.
- NC \*A 10/82 (-) North Carolina adopted fee schedules for podiatrists. These rates use the 75th percentile of charges in 1979 as the base.

- \* OR \*A 3/83 (+) Oregon raised its reimbursement rates for podiatrists from 90 percent to 100 percent of the maximum fees paid to physicians for the same medical and surgical procedures.
- OR \*A 5/82 (-) Oregon reduced podiatrists' fees from 100% to 90% of the maximum fees paid to physicians for the same medicine and surgery procedures. It continued paying 100% of the maximum physician fees for lab and x-ray services.
- OR \*A 3/82 (-) Oregon reduced podiatrists' fees for higher level visits to match fees for mid-range level visits to control "creep" in billing of higher level codes.
- OR \*A 2/82 (-) Oregon reduced podiatrists' fees for selected surgical procedures in order to achieve more equitable relative values and control expenditures overall.

## 12. Chiropractic Services

### A. Amount, Duration and Scope

- ID \*X 2/83 (-) Idaho proposed to eliminate chiropractic services. However, this proposal was dropped.
- ID \*A 9/82 (-) Idaho lowered the maximum number of allowed chiropractic visits from three to two per month.
- IL \*A 6/82 (-) Illinois dropped coverage of chiropractic services for the adult AFDC medically needy, general assistance, and aid to medically indigent recipients.
- \* KS \*A 8/83 (+) Kansas modified its coverage of chiropractic services. The May 1983 limit to one procedure was rescinded; Kansas will, retroactive to July 1, 1983, reimburse chiropractors for necessary office visits and x-rays. A limit of 24 office visits per calendar year will be absolute--neither prior authorization nor medical necessity will allow exceptions. (The limit for Medi-Kan, i.e., state-only, recipients will remain 12 visits per calendar year; there will be no exceptions.) A new benefit was added--chiropractic, history and physical--with a limitation of one per year.
- To offset resultant higher costs, the maximum allowable rates of reimbursement for certain procedures were reduced.
- \* KS \*A 5/83 (-) Kansas limited coverage of chiropractic services to one procedure: the modality, Diathermy. A Medicaid recipient is allowed up to two diathermy visits per month, with one diathermy modality per visit. Medi-Kan (state-only) recipients are under the same limitations; however, they are also limited to 12 visits per calendar year.
- MI \*X 1/82 (-) The State of Michigan proposed eliminating chiropractic services as a covered benefit. This proposal was dropped.
- \* NE \*P /83 (-) Nebraska proposes to delete coverage of chiropractic x-rays.
- NE \*A 8/82 (-) Nebraska limited chiropractic services to examination, history, adjustment, physical therapy, and x-rays as covered.

- \* NH \*A 7/83 (+) New Hampshire raised its limits on chiropractic services from 4 to 6 services per recipient per year.
  
- NC \*A 7/82 (+) North Carolina increased from 18 to 24 the number of allowed visits to one or a combination of the following services: outpatient hospital departments (excluding emergency rooms); rural health clinics; physicians; clinics (except mental health centers); optometrists; podiatrists; and chiropractors. Exemptions from the limitation did not change.
  
- SC \*A 1/82 (-) South Carolina eliminated coverage of chiropractic services.
  
- \* WA \*A 7/83 (+) The state of Washington reinstated coverage of chiropractic services for the categorically needy.
  
- \* WI \*A /83 (-) (SB 83) The Wisconsin legislature enacted into law a provision which limits reimbursement of chiropractors to those services that qualify for federal cost-sharing.

#### B. Utilization Controls

- IA \*A 4/82 (-) Iowa instituted a \$.50 copayment on chiropractors' services for total covered service rendered on a given date.
  
- \* KS \*A 5/83 (-) Kansas increased the copayment from \$.50 to \$1.00 for the following services:
  - Psychologist services (per visit, per date of service);
  - Chiropractic services (per visit, per date of service);
  - Dental services (per visit, per date of service);
  - Optometric services (per visit, per date of service); and
  - Pharmacy services (per prescription, new and refill).



- \* MI \*A 7/83 (-) (HB 4558) Michigan's Appropriations Act requires the Department of Social Services to impose copayments on dental, podiatric, vision, chiropractic and hearing aid services for recipients over 21 years of age.
- MI \*A 1/82 (-) The State of Michigan implemented a \$1.00 co-payment on chiropractic services for Title XIX recipients 21 and older and for all General Assistance recipients.
- SC \*A 1/82 (-) South Carolina no longer charges a \$.50 per visit copayment on chiropractic services, since this benefit was dropped in January 1982.
- \* SD \*A 7/83 (-) South Dakota imposed recipient cost-sharing of \$.50 for each chiropractic procedure billed.

### C. Reimbursement

- CA \*A 8/82 (-) California reduced fees for chiropractic services by 10 percent.
- \* KS \*A 8/83 (+) Kansas modified its coverage of chiropractic services. The May 1983 limit to one procedure was rescinded; Kansas will, retroactive to July 1, 1983, reimburse chiropractors for necessary office visits and x-rays. A limit of 24 office visits per calendar year will be absolute--neither prior authorization nor medical necessity will allow exceptions. (The limit for Medi-Kan, i.e., state-only, recipients will remain 12 visits per calendar year; there will be no exceptions.) A new benefit was added--chiropractic, history and physical--with a limitation of one per year.  
  
To offset resultant higher costs, the maximum allowable rates of reimbursement for certain procedures were reduced.
- \* NC \*A 7/83 (-) (SB 23) The North Carolina legislature enacted a law which provided that there be no increase in fees of Physicians, Chiropractors, Podiatrists, Optometrists, and Dentists.
- NC \*A 10/82 (-) North Carolina adopted fee schedules for chiropractors. These rates use the 75th percentile of charges in 1979 as the base.

### 13. Physical Therapy Services

#### A. Amount, Duration and Scope

- \* AL \*A 7/83 (-) Within a calendar year each Alabama Medicaid recipient is now limited to no more than a total of twelve physician visits in any combination of office, hospital outpatient, or nursing home settings. Visits counted under this quota will include, but not be limited to, visits for: prenatal care, postnatal care, family planning, second opinions, consultations, referrals, EPSDT referrals, immunizations, injections, psychotherapy, physical therapy and care by ophthalmologists for eye disease.

Physician hospital visits do not count toward this limit: recipients hospitalized are entitled to the physician visits that are medically necessary during the hospital days that are paid for by Alabama Medicaid.

Psychiatric evaluation or testing, psychotherapy visits, group therapy and family therapy visits are counted as part of the yearly quota of 12 visits for each recipient.

Ancillary services, when performed by a physician or under his supervision, can be billed by the physician without counting as an office visit. (Example: drug injection, laboratory and x-ray.)

- AK \*A 7/82 (+) Alaska added coverage of physical therapy services. Prior authorization is required after 36 treatments. Previously, Alaska provided physical therapy solely for its state-only funded individuals.
- \* FL \*P /83 (+) (HB 757) The Florida legislature reports introduction of a bill to add coverage of physical therapy.
- \* KS \*A 5/83 (-) Kansas deleted coverage for restorative physical, speech, and occupational therapy provided by Medicare-certified rehabilitation facilities. These were the only services provided by rehabilitation facilities which the state had previously covered.

- MI \*A 4/82 (-) Physical therapists have been enrolled and are now able to bill Medicaid for Medicare coinsurance and deductible amounts for services rendered in their own offices.
- MO \*P 1/83 (-) Missouri has proposed to establish computer edits to enforce a policy to limit payments for physical and occupational therapy to adaptive therapy in the use of a prosthetic or orthotic device.
- \* NE \*A 9/82 (-) Nebraska added active treatment and medical necessity requirements to outpatient therapeutic services.

## **B. Utilization Controls**

- CA \*A 9/82 (-) The California Legislature tightened utilization controls, including prior authorization, on physical therapy, occupational therapy, and speech therapy services. All physical therapy services will require prior authorization with the exception of initial evaluations and re-evaluations in outpatient rehabilitation centers. All speech and occupational therapy performed in a SNF or ICF will require prior authorization. Independent practitioners providing speech and occupational therapy outside a SNF or ICF may continue to accept Medi labels (two per month), as previously allowed.
- IA \*A 4/82 (-) Iowa instituted a \$.50 copayment on physical therapy, for total covered service rendered on a given date.

## **C. Reimbursement**

- ID \*A 9/82 (-) Idaho established maximum reimbursement levels on physical therapy services.

#### 14. Occupational Therapy

##### A. Amount, Duration and Scope

- AK \*A 7/82 (+) Alaska added coverage of occupational therapy services. Prior authorization is required after 36 treatments. Previously, Alaska provided occupational therapy solely for its state-only funded individuals.
- \* KS \*A 5/83 (-) Kansas deleted coverage for restorative physical, speech, and occupational therapy provided by Medicare-certified rehabilitation facilities. These were the only services provided by rehabilitation facilities which the state had previously covered.
- MO \*P 1/83 (-) Missouri has proposed to establish computer edits to enforce a policy to limit payments for physical and occupational therapy to adaptive therapy in the use of a prosthetic or orthotic device.
- \* OR \*A 3/82 (+) Oregon added certain occupational therapy services for all ages. Prior authorization is required except for the initial evaluation.

##### B. Utilization Controls

- CA \*A 9/82 (-) The California Legislature tightened utilization controls, including prior authorization, on physical therapy, occupational therapy, and speech therapy services. All physical therapy services will require prior authorization with the exception of initial evaluations and re-evaluations in outpatient rehabilitation centers. All speech and occupational therapy performed in a SNF or ICF will require prior authorization. Independent practitioners providing speech and occupational therapy outside a SNF or ICF may continue to accept Medi labels (two per month), as previously allowed.
- \* OR \*A 3/82 (+) Oregon added certain occupational therapy services for all ages. Prior authorization is required except for the initial evaluation.

##### C. Reimbursement



## 15. Speech, Hearing, and Language Therapy

### A. Amount, Duration and Scope

- \* FL \*P /83 (+) (HB 757) The Florida legislature reports introduction of a bill to add coverage of speech pathology.
- \* KS \*A 5/83 (-) Kansas deleted coverage for restorative physical, speech, and occupational therapy provided by Medicare-certified rehabilitation facilities. These were the only services provided by rehabilitation facilities which the state had previously covered.
- OR \*A 3/82 (+) Oregon added certain speech therapy services for all ages. Prior authorization is required except for the initial evaluation.

### B. Utilization Controls

- CA \*A 9/82 (-) The California Legislature tightened utilization controls, including prior authorization, on physical therapy, occupational therapy, and speech therapy services. All physical therapy services will require prior authorization with the exception of initial evaluations and re-evaluations in outpatient rehabilitation centers. All speech and occupational therapy performed in a SNF or ICF will require prior authorization. Independent practitioners providing speech and occupational therapy outside a SNF or ICF may continue to accept Medi labels (two per month) as previously allowed.

### C. Reimbursement

## 16. Audiologist Services

### A. Amount, Duration and Scope

### B. Utilization Controls

- IA \*A 4/82 (-) Iowa increased its copayment on audiologists' services from \$1.00 to \$2.00 for total covered service rendered on a given date.
- MO \*A 5/82 (-) Missouri implemented pre-payment reviews of all audiology claims to determine that a hearing aid evaluation form is submitted and properly completed, that a physician has examined the patient, that a hearing evaluation has been performed, and that the need exists for a hearing aid. Pre-payment review of all audiology claims is supported by the Audiology Subcommittee of the state's Medical Advisory Committee.
- MO \*A 5/82 (-) In Missouri, binaural hearing aids now require prior authorization and must be prescribed by an ear specialist.
- \* NM \*A 7/83 ( ) New Mexico eliminated its prior approval requirement for certain audiologist services.

### C. Reimbursement

## 17. Other Non-physician Practitioner Service

### A. Amount, Duration and Scope

- CT \*A 7/82 (-) The State of Connecticut has implemented a policy of paying for the services of psychiatric social workers under the supervision of psychiatrists.
- MA \*P 1/82 (+) (H 1778) The Massachusetts legislature reports that a bill was introduced to provide reimbursement to RNs for services for which other practitioners receive reimbursement.
- \* NY \*P /83 (+) New York is proposing to add coverage in 1984 of services provided by nurse-midwives in private practice. Costs should offset expenses currently incurred in clinics, hospitals or physicians' offices.

### B. Utilization Controls

### C. Reimbursement

- CA \*A 9/82 (-) California reduced fees for acupuncture services by ten percent.
- OR \*A 5/82 (-) Oregon reduced fees for naturopath services from 100% to 80% of the maximum physician fees for the same medicine and surgery procedures. Lab and x-ray fees continue at 100% of physician fee levels.
- OR \*A 3/82 (-) Oregon reduced fees for higher level naturopath visits to match fees for mid-range level visits in order to control "creep" in billing higher level codes.

## 18. Psychologist Services

### A. Amount, Duration and Scope

- \* AL \*A 4/83 (-) Alabama limited psychotherapy, group therapy and family therapy, when medically necessary, to twenty-four visits per recipient per calendar year. Psychiatric evaluation or testing, when medically necessary and given by a physician in person, is limited to one per calendar year.
- CA \*A 7/83 (-) The California legislature mandated the development of pilot projects to test the feasibility and cost-effectiveness of consolidating administration of mental health services through the California Short-Doyle program. Under these arrangements psychology/psychiatric services would be eliminated as Medi-Cal benefits and all patients would be directed to utilize Short-Doyle providers for mental health services. A federal waiver to implement this pilot is being pursued.
- \* GA \*A 11/82 (+) Georgia removed the copayment from the Psychology Program.
- IA \*A 5/82 (+) Iowa has added coverage of independently practicing psychologists.
- \* KS \*A 5/83 (-) Kansas placed a limitation of 24 hours per calendar year on individual psychological services by a psychologist. Excepted from this limitation are recipients enrolled in the EPSDT program and the children's Special Psychiatric Program who may receive services, with prior authorization, of up to \$284 per month (they must receive a minimum of two visits of 30 minutes each per week for two years).
- \* KS \*A /83 (-) Kansas began requiring that psychological testing and evaluation be prior authorized after the first two hours of service. Psychological testing must be performed by a certified Ph.D. psychologist and is limited to six hours every two years.
- Admission evaluation, which is a separate procedure, is limited to five hours of evaluation per calendar year.
- MA \*A 12/82 (+) Massachusetts began covering neuro-psychological exams on a prior approval basis.



- MA \*A 11/82 (-) Massachusetts dropped coverage of the services of school psychologists.
- \* NE \*A 5/83 (+) Nebraska expanded its procedure codes for psychiatric services.
- VA \*A /82 ( ) The Virginia legislature enacted HB 598, which authorizes direct contracts between the Medicaid agency and clinical psychologists.

## B. Utilization Controls

- \* KS \*A 5/83 (-) Kansas increased the copayment from \$.50 to \$1.00 for the following services:
- Psychologist services (per visit, per date of service);
- Chiropractic services (per visit, per date of service);
- Dental services (per visit, per date of service);
- Optometric services (per visit, per date of service), and
- Pharmacy services (per prescription, new and refill).
- \* KS \*A /83 (-) Kansas began requiring that psychological testing and evaluation be prior authorized after the first two hours of service. Psychological testing must be performed by a certified Ph.D. psychologist and is limited to six hours every two years.
- Admission evaluation, which is a separate procedure, is limited to five hours of evaluation per calendar year.
- NJ \*A 2/82 (-) The State of New Jersey requires prior authorization of psychiatric/psychological services in long term care facilities and boarding homes after an initial evaluation.

## C. Reimbursement

- CA \*A 8/82 (-) California reduced fees for psychology services by 10 percent.

\* NE \*A 9/82 (-) Nebraska added requirements for licensure and certification as a clinical psychologist for independent providers who are psychologists; it added "licensed M.S. and Ph.D. psychologists" and "qualified masters-level mental health staff members" to persons included under psychiatric allied health staff (allied health staff may assist in various tasks, such as the development of treatment plans for patients and utilization review); and revised testing and evaluation to allow licensed and certified clinical psychologists to perform tests on their own (while other licensed psychologists must have psychologists'/physician's orders for testing and evaluation).

## 19. Lab and X-Ray Services

### A. Amount, Duration and Scope

- \* KS \*A 2/83 (-) Kansas eliminated coverage of three laboratory tests: Vitamin B6 Level-Serum, Vitamin E Level-Serum, and the Denver Development Screen.
- \* KS \*A 2/83 (-) Kansas eliminated coverage of arterial puncture if billed on the same day as any laboratory test, when both are billed by the same provider.
- MI \*P 1/83 (-) Michigan is proposing to adopt an occurrence and dollar limit on laboratory services performed in the outpatient hospital, independent laboratory and physician's office. Services over these limits will require medical documentation to justify payment.
- MI \*A 9/82 (-) Michigan restricted certain pathology procedures to laboratory and hospital settings. The state will no longer reimburse physicians for this service. (Estimated annual savings: \$1.3 million.)
- MI \*A 1/82 (-) Michigan dropped coverage of complete blood counts and urinalyses for pre-surgical patients when performed routinely by hospital laboratories. These tests must now be ordered and hand-signed or initialed by the physician.
- \* NH \*A 7/83 (+) New Hampshire raised its limits on laboratory tests from 20 to 24 tests per recipient per year.
- \* NH \*A 7/83 (+) New Hampshire raised its limits on diagnostic x-rays from 12 to 15 x-ray services per recipient per year.

### B. Utilization Controls

- CA \*A 8/82 (-) The California Legislature reduced fees for portable X-ray services by ten percent. In addition, more stringent utilization controls are to be implemented.

### C. Reimbursement

- CA \*A 10/82 (-) California reduced the rates for outpatient laboratory and pathology services by an average of 25 percent, with rates for individual services adjusted by more or less than 25 percent to reflect technological changes. Pathology procedures may only be billed by the provider actually performing the procedure.
- CA \*A 8/82 (-) The California Legislature reduced fees for portable X-ray services by ten percent. In addition, more stringent utilization controls are to be implemented.
- ID \*P 2/83 (-) Idaho proposes to change the reimbursement methodology for hospital outpatient lab and x-ray services from a reasonable cost basis to a fee schedule system.
- \* KS \*A 9/83 (-) Kansas will no longer directly reimburse mobile x-ray providers for services performed in either the inpatient or outpatient setting of a hospital. The state will make payment for these services to the hospital which will be responsible for paying the mobile x-ray provider. In addition, no mileage allowance will be granted for mobile x-ray providers.
- LA \*A 3/82 (-) Louisiana now requires all independent laboratories, when they bill the Medical Assistance Program, to show pricing preferentials and discounts allowed to physicians, hospitals, and other independent laboratories, in addition to their usual and customary charge.
- \* ME \*A 8/83 (+) Maine revised allowances for independent laboratory and x-ray services by increasing payment amounts for certain procedures and by initiating certain other new procedure codes.
- MD \*A 7/82 (+) Maryland increased its rates for nursing homes, laboratories, physicians, pharmacists, dentists, medical supplies and equipment, ambulances and wheelchair vans, and medical day care.
- MI \*A 9/82 (-) In Michigan, reimbursement for certain radiology/diagnostic procedures was reduced 20%. (Estimated annual savings: \$1.2 million.)



MI \*P 4/82 (-) The State of Michigan is considering the volume purchase of laboratory services and a manufacturer rebate plan for certain drugs.

MI \*A 4/82 (-) Michigan reduced by 10 percent its fee screens for the following lab tests:

Code	Description
6650	Thyroxine, free, by analysis
6661	Tri-iodo-thyronine
6700	Thyroid stimulating hormone
6850	Thyroxine binding globulin
8227	T-3 uptake
8228	Thyroxine (T-4), Total
8233	Thyroxine Binding Globulin (TBG)
8234	Thyroid Stimulating Hormone (TSH)
8238	Tri-Iodo-Thyronine (T-3 Hormone)
8517	Immunodiffusion, quantitative, IGA, etc.
8887	Culture, aerobic, other than blood and urine, definitive
8888	Culture, urine, definitive, with colony count

Reimbursement levels were reduced by twenty percent for the following tests: Vitamin B-12 (6750) and Folic acid (folate) (6751 and 8138).

NV \*A 10/83 (-) Nevada began to purchase non-hospital lab services through sole source contracts with two private laboratories for provision of all covered lab procedures within two geographic areas: the Reno area, where one provider will serve three counties; and the Las Vegas area, where one provider will serve Clark County and nearby locations. The rest of the state will continue to use a fee-for-service approach.

NJ \*C /82 (-) New Jersey is considering competitive bidding for selecting providers of independent laboratory services.

\* NC \*A 7/83 (-) (SB 23) The North Carolina legislature enacted a law which reimburses, independent lab and x-ray services at 90 percent of allowable usual and customary charges, subject to a 7 percent limit on rate increases.

VA \*A 7/82 (-) Virginia changed its reimbursement methodology for outpatient laboratory services in hospitals from a cost basis to fee-for-service.

WA \*A 7/82 (-) The state of Washington reduced rates for common laboratory procedures by ten percent.

WI \*A 2/82 (-) The State of Wisconsin began reimbursing for laboratory and x-ray services provided by a hospital for outpatients at a rate comparable to that paid independent providers of such services. This policy does not apply for services provided to hospitalized recipients. In November 1981, Wisconsin standardized rates to independent providers.

## 20. Prescribed Drugs

### A. Amount, Duration and Scope

- |   |    |    |          |  |
|---|----|----|----------|--|
| * | AL | *A | /83 (-)  | Alabama reduced the coverage of drug prescriptions from an unlimited number to six prescriptions per month.  |
| * | AR | *A | 1/83 (+) | Arkansas increased from three to four the maximum number of prescriptions covered per recipient per month.   |
|   | CT | *X | 2/82 (-) | The Connecticut legislature reported the introduction of bills to require providers to dispense generic drugs as substitutes for brand name drugs. These proposals were dropped.   |
| * | GA | *A | 7/83 (+) | Georgia added oral iron to its drug formulary.   |
| * | GA | *A | 5/82 (+) | Georgia rescinded a 1981 regulation replacing all anti-rheumatics (arthritis medications) in its drug formulary with enteric-coated aspirin.   |
| * | GA | *A | 5/82 (+) | Georgia added injectible antibiotics to its drug formulary.  |
| * | HI | *P | /83 (-)  | Hawaii is revising its drug formulary, with the cooperation of the Pharmaceutical Association of Hawaii, in order to effect a cost savings.  |
|   | ID | *A | 9/82 (-) | Idaho lowered the cap on drug coverage per recipient per month from \$35 to \$30. Excluded from this cap are certain contraceptives.   |
| * | IL | *A | 1/84 (+) | As a result of legislative action, Illinois reinstated coverage of certain drugs, dropped in July 1983, used to treat arthritis.   |
| * | IL | *A | 7/83 (-) | Illinois eliminated certain drugs from its formulary. Drugs which will no longer be covered include certain anti-microbials for self-limiting infections, analgesics, psychotherapeutic anti-anxiety drugs and sedatives, allergic antihistamines, and superficial anti-inflammatives. |
| * | IL | *A | /83 (-)  | Illinois began, on an ongoing basis, adding and deleting drugs from its formulary. A Pharmacological Panel and Drug and Therapeutics Committee composed of pharmacologists and physicians, makes the recommendations to the Medicaid Department.                                       |

IL \*A 7/82 (-) Illinois organized all covered drugs into therapeutic categories and implemented a policy whereby the state will pay for brand name drugs listed in its formulary only if no generic substitutes exist for the drugs.

IL \*A 7/82 (-) Illinois limited its drug coverage for the non-pregnant AFDC adult medically needy, general assistance, and aid to the medically indigent recipients to those drugs necessary for life maintenance. The covered drugs are specified; however, prior authorization may be given for other drugs that are necessary to sustain life.

IL \*A 7/82 (-) The State of Illinois placed increased emphasis on its policy requiring that each time a manufacturer seeks to add a new drug to the Program's formulary, the state opens up that entire therapeutic classification for review by its Pharmaceutical Panel and its Drug and Therapeutics Committee for the purpose of deleting inefficient drugs or high cost drugs for which lower cost substitutes are available.

\* KS \*A 1/83 (-) Kansas modified its drug program by publishing a listing of drugs reflecting program coverage. Any drugs not appearing on the list are no longer covered. In addition, new drug products will no longer be automatically added to the drug file for claims processing and included as covered service.

\* KS \*A 1/83 (-) Kansas dropped coverage of most cold and cough preparations and vitamins. The program will, however, still cover pre-natal vitamins when prescribed for pregnancy-related conditions.

KS \*A 10/82 (-) Kansas deleted coverage of 36 drug products and their generic equivalents, most of which fall into the therapeutic categories of shampoos and skin anti-infectives.

KY \*A 7/82 ( ) Kentucky revised its listing of therapeutically equivalent drug products. Substitution of drugs under the KMAP will conform to regulations promulgated by the Kentucky Board of Pharmacy.



By statute, the Board has the responsibility for this function, and will use as one reference the FDA publication regarding bioavailability and therapeutic equivalence evaluations.

	KY	*A	2/82 (-)	Kentucky will review and revise the Medical Assistance drug formulary to ensure that only those medications which are needed in the treatment of illnesses are included. Items of questionable medical value will be removed from the authorized drug list. (Contact: Anita Crask 502/564-5560)
*	LA	*P	/83 (-)	Louisiana proposes to implement a formulary for drugs.
	LA	*A	10/82 (-)	Louisiana reduced the prescribed drug program by deleting coverage of Heptavax-B.
	LA	*A	9/82 (-)	Louisiana deleted drugs deemed similar and related to less-than-effective drugs.
*	ME	*A	8/83 (+)	Maine added coverage of pre-natal vitamins for pregnant women.
	MA	*A	3/82 (-)	Massachusetts no longer pays for preparations containing hexachlorophene, U.S.P., as the major active ingredient. (Contact: Pat Canney 617/727-8082.)
*	MI	*A	8/83 (-)	Michigan eliminated additional less-than-effective drugs from coverage.
*	MI	*A	8/83 (-)	Michigan increased by 13 the number of pharmaceutical items subject to maximum allowable cost limitations.
*	MI	*A	4/83 (-)	Michigan eliminated potassium supplements from coverage.
	MI	*A	4/82 (-)	Michigan eliminated chemically equivalent drugs from coverage. (Estimated annual savings: \$1.2 million.)
	MI	*A	1/82 (-)	Michigan eliminated less-than-effective drugs from coverage. (Estimated annual savings: \$2.4 million.)

MI	*A	1/82 (-)	The State of Michigan eliminated pharmacy coverage of laxative, antacid, antivertigo, vitamin (except pre-natal preps and pediatric fluoride drops), hematinic, and cough and cold legend drugs. (Estimated annual savings: \$5.5 million.)
MI	*A	1/82 (-)	The State of Michigan has eliminated the exception policy for its drug formulary (two drugs, Ativan and Valium, were covered for certain diagnoses/conditions even though they did not appear in the formulary). As a result, Ativan and Valium are not covered under the state's Medicaid program.
*	MN	*A 6/83 (-)	(SF 1234) The Minnesota legislature enacted a law which expanded the list of drugs that cannot be included in the drug formulary to include certain over-the-counter drugs.
*	MN	*P /83 (+)	(SF 254) The Minnesota legislature reports introduction of a bill to reinstate nutritional supplements to the drug formulary.
MO	*A	3/83 ( )	Missouri implemented a demonstration project to provide certain specified non-steroidal drugs on a prior authorization basis. These drugs had previously been covered and then dropped from coverage, and are now available with prior authorization only.
MO	*A	2/82 (-)	Missouri has removed certain more costly brand names from its drug formulary.
*	NE	*A /82 (-)	Nebraska eliminated coverage of ten products. These include items such as experimental medications, liquors, items recommended or prescribed for weight control or appetite suppression (this would not apply to children with narcolepsy or hyperkinesis), and medical supplies and certain medications for patients in long term care facilities.
NV	*A	3/82 (-)	Nevada previously covered three prescriptions per month plus those a physician designates as "emergency." The state as of March 1982 deleted coverage of "physician-designated emergency" prescriptions.
NH	*A	8/82 (+)	New Hampshire removed the limit of three prescriptions per month per recipient. (The state simultaneously implemented a \$1 copayment on prescription drugs and refills.)

NH \*A 8/82 ( ) New Hampshire dropped its drug dispensing limitation per prescription of a 100-day or 100-dosage units maximum supply. Instead, the state implemented a requirement that maintenance medication must be prescribed and/or dispensed in a quantity sufficient to treat the recipient for at least 34 days or in a package of 100 dosage units, whichever is greater.

NM \*A 8/82 (-) (HB 114) The New Mexico legislature enacted a law which allows pharmacists to prescribe equivalent drugs and which limits reimbursement to the wholesale cost of the less expensive equivalent drugs plus a dispensing fee.

\* NC \*A 7/83 (-) (SB 23) The North Carolina legislature enacted a law which limits to six the number of covered prescriptions, including refills, per recipient per month.

NC \*A 7/82 (+) North Carolina increased from 4 to 6 the number of allowed prescriptions per month. Exempted from the limit are drugs prescribed for the following illnesses/treatments: end-stage renal disease, chemotherapy/radiation therapy for malignancy, acute sickle cell disease, end-stage lung disease, unstable diabetes, hemophilia, and the terminal stage of any life-threatening illness.

\* OH \*C /83 ( ) Ohio is considering revising its drug formulary.

OR \*A 11/82 (-) Oregon began covering Isotretinoin with prior authorization.

\* PA \*C /83 (-) Pennsylvania is considering termination of payment for minor tranquilizers.

RI \*A 5/82 (-) Rhode Island began requiring that all prescriptions written for valium and other drugs falling into the Benzodiazepine classification be an original prescription (no refills). Nursing home residents are exempt.

RI \*A 4/82 (-) Rhode Island modified its policies regarding maintenance drugs, requiring that they be prescribed in quantities of 100 tablets or capsules or a pint of liquid, or a one-month's supply, whichever is greater. Exceptions will be made for certain medical reasons, in extraordinary cases, and for the initial prescription of a drug. This policy should



reduce outlays for dispensing fees of these drugs.

\* SC \*A 6/83 (+) South Carolina added a select group of over-the-counter drugs to its formulary.

SC \*X 7/82 (+) The South Carolina Health Care Planning and Oversight Commission proposed that the Medicaid program use an open formulary, covering all drugs listed in the F.D.A.'s National Drug Code (NDC). This proposal has been dropped.

SC \*A 1/82 (-) South Carolina reduced coverage of prescription drugs from four to three per month per recipient.

\* SD \*A 7/83 (-) South Dakota limited coverage of certain drugs to their generic form.

TN \*A 7/82 (+) In July 1981 Tennessee had eliminated coverage of the following services for most medically needy recipients: inpatient and outpatient hospital services, physician and pharmacy services, prosthetic devices, and Christian Science sanatoria services. Among the medically needy groups still able to receive physician and pharmacy services were nursing home residents. A federal court later ruled that this discriminated by class (according to living arrangements), and required the state to retroactively pay for services denied to medically needy recipients during this period. Tennessee therefore in July 1982 increased coverage for the medically needy; they will now receive the same services as the categorically needy. At the same time, Tennessee reduced its medically needy eligibility population to only pregnant mothers and children under 21 in special groupings.

TX \*A 4/82 (-) Texas adopted a final rule, effective April 1, 1982, limiting coverage of vitamins and multiple ingredient anti-anemia drug products to vitamins K and D3, fluoride for children and products containing iron in its various salts.

VA \*A 7/82 (-) Virginia began requiring that all drug prescriptions be filled with generic items listed in the Virginia formulary.

WV \*A 3/82 (+) West Virginia reinstated coverage of certain prescription drugs for medically needy recipients.



WV \*A 3/82 (-) West Virginia reduced the number of drugs listed in the drug formulary.

WV \*A 1/82 (-) West Virginia eliminated coverage of "minor" tranquilizers such as Valium, Librium, Azenes, and Activan.

WV \*A 1/82 (-) West Virginia eliminated coverage of prescription drugs for medically needy recipients.

WV \*A 1/82 (-) West Virginia eliminated coverage of non-legend drugs, with the exceptions of family planning products, insulin and syringes, and renal (ESRD) supplies.

#### **B. Utilization Controls**

\* AL \*A 7/83 (+) Alabama expanded its list of exceptions to the drug copayment requirement to include pregnant women and recipients under 21 years of age (as well as those receiving family planning prescriptions and nursing home residents). This change, which requires state legislation, brings Alabama into conformity with current federal requirements.

\* AL \*A 7/83 (-) Prescriptions dispensed to Alabama Medicaid recipients, both original and authorized refills, are limited to no more than six per calendar month.

\* AL \*A 10/82 (-) Alabama implemented a variable rate copayment on Medicaid drug prescriptions. The amount of the copayment is based on the following schedule:

Drug Ingredient Cost	Copayment
\$ .01 to \$ 8.24	\$ .50
\$ 8.25 to \$23.24	\$1.00
\$23.25 to \$48.24	\$2.00
\$48.25 or more	\$3.00

\* AR \*A 12/82 (+) Arkansas eliminated its prescription drug copayment.

\* CA \*A 5/82 (-) The California state legislature approved a bill to implement a \$1.00 copayment on drug prescriptions for all Medi-Cal recipients, both categorically needy and medically needy, with the exception of children under 12, aged persons, persons with chronic conditions requiring multiple prescriptions, and persons

who are inpatients in a health facility. Copayments are collected by or obligated to the provider at the time the service is rendered. At the provider's option, the copayment amount may be waived. Any copayment collected is in addition to the usual program reimbursement. The program began May 1982, after California received an 1115 waiver.

CA \*P /82 (-) The California legislature mandated a mandatory \$1 copayment for each drug prescription dispensed. Currently, the collection of a copayment is at the discretion of the pharmacist. This modification to the California waiver on copayment (Section 1115) was not approved by HCFA and thus has not been implemented. However, California has proposed a change in state law to implement the mandatory copayment.

DE \*P 1/83 (-) Delaware proposes to implement a copayment on pharmacy services, with the exclusion of:

- individuals under age 18,
- pregnant women,
- individuals in nursing homes,
- family planning drugs and supplies, and
- Medicare coinsurance and deductibles.

The copayment will be \$.50 on services up to and including \$10.99, and \$1.00 for services \$11.00 and over.

FL \*A 4/82 (-) In Florida drug utilization review (DUR) program has been developed. The therapeutically-oriented DUR program addresses the quality implications of drug therapy. The goals of therapeutic DUR are (1) to eliminate those drug therapies which block/retard successful therapy, and (2) to reduce drug-induced hospitalization, which should result in significant savings. When contraindicated drug prescriptions are identified, letters are sent to the prescribing physicians explaining the problem. Many physicians have reacted positively to this program. (Contact: Rod Presnell 904/488-9990).

\* ID \*A 3/83 (+) Idaho dropped the \$.50 per prescription drug copayment.

IN \*X 1/82 (+) The Indiana legislature reported that a bill was introduced to prohibit the imposition of a copayment on drugs. This proposal was dropped.

- \* KS \*A 8/83 (-) Kansas placed three drugs: Minocycline, Oxytetracycline and Demeclocycline on the listing of services covered only with prior authorization.
  
- \* KS \*A 5/83 (-) Kansas increased the copayment from \$.50 to \$1.00 for the following services:  
  
 Psychologist services (per visit, per date of service);  
  
 Chiropractic services (per visit, per date of service);  
  
 Dental services (per visit, per date of service);  
  
 Optometric services (per visit, per date of service); and  
  
 Pharmacy services (per prescription, new and refill).
  
- ME \*A 2/82 (-) The state of Maine imposed a \$.50 copayment on prescription drugs for all non-institutionalized Medicaid recipients. It subsequently responded to additional copayment exemptions required by TEFRA 1982.
  
- \* MD \*A 1/83 (+) Maryland eliminated copayments for federal category recipients. (State-only funded recipients are required to pay \$0.50 for prescriptions except for those resulting from EPSDT and family planning services.)
  
- \* MI \*A 7/83 (-) Michigan's Appropriations Act contains a provision that requires a copay of \$.50 per prescription for recipients over 21, excluding persons in institutions, pregnancy-related products, and products on the MAC list.
  
- MI \*A 8/82 (-) The State of Michigan expanded its \$.50 drug copayment policy to all drugs except those with MAC limits.
  
- MI \*A 4/82 (-) Michigan began closely reviewing laboratory services for above average use. A provider suspected of abuse will be referred for possible audit and recovery of funds.
  
- \* MN \*A 6/83 (-) (SF 1234) The Minnesota legislature enacted a law which authorized prior authorization for certain formulary drugs.



\* MS \*A 11/82 (+) Mississippi eliminated its \$.50 drug copayment.

\* MO \*P 9/83 (-) Missouri is proposing to establish a drug utilization review committee to review claims for appropriateness of drug therapy. When contraindication of drug usage is found, providers will be educated.

MO \*A 7/82 (-) Missouri implemented a copayment on drugs, as a result of the passage of HB 1089 by the Missouri legislature.

MO \*P 2/82 (-) Missouri proposes to establish a drug utilization review committee to review abusive recipients and providers.

\* NE \*A 5/83 (-) Nebraska added several items to the list of products which must be pre-authorized. These included various drugs, transdermal therapeutic systems, and vitamins other than those covered by the State Maximum Allowable Cost listing.

\* NE \*A /82 (-) Nebraska began requiring prior authorization for the provision of certain products, including anti-obesity (anorexic agents), dietary supplements, bath oils and skin lotions, and methaqualone.

\* NH \*A 7/83 (+) New Hampshire reduced its copayment on drug prescriptions from \$1 to \$.75.

NH \*A 8/82 (-) New Hampshire implemented a \$1 copayment on all prescription drugs and refills with the exception of those for family planning purposes, those related to pregnancy, and those written for the use of nursing home residents or recipients under age 18. (The state simultaneously dropped a limitation of three prescriptions per month per recipient.)

\* NJ \*A /83 (-) New Jersey expanded, in late 1983, its mandatory pharmacy lock-in program to other providers such as physicians. Previously, overutilizers of these services could participate in a voluntary lock-in program.

\* NM \*A 7/83 (+) New Mexico eliminated its drug copayment.

NC \*P 10/82 (-) North Carolina proposed to institute recipient lock-ins for over-users of pharmacists' services.



	NC	*A	6/82 (-)	North Carolina began requiring recipients to use only one pharmacy per month, except in emergencies.
*	OH	*A	3/84 (-)	Ohio implemented a pharmacy lock-in program.
*	OH	*C	/83 (-)	Ohio is considering a proposal for a drug utilization review and provider education program.
*	OH	*A	/83 (-)	(HB 291) The Ohio legislature enacted a law which mandates a pharmacy lock-in for recipients who overutilize services, and a phased-in expansion of the lock-in to other service providers.
	OR	*X	/82 (-)	Oregon considered the imposition of copayments on drugs. However, this was later dropped.
	PA	*X	/82 (-)	The Pennsylvania legislature considered a bill to impose a \$.50 copayment on drug prescriptions. However, this bill is no longer under consideration.
	RI	*X	4/82 (-)	Rhode Island proposed to require of all Medically Needy Only recipients a drug copayment of \$.50 per prescription. This proposal was dropped.
	SD	*A	7/82 (-)	South Dakota increased prescription drug copayments from \$.50 to \$1.00 per prescription.
	TX	*A	10/82 (+)	Texas eliminated its \$.50 copayment on prescription drugs.
	TX	*A	9/82 (-)	Texas began requiring a recipient copayment of \$.50 for each prescription.
	TX	*A	9/82 (-)	Texas implemented a lock-in program for recipients overutilizing physician and/or pharmacy services. Overusers may be locked in to one physician, one pharmacy or both. The physician lock-in affects physician services in all settings, including office visits, outpatient care, and emergency room services.
	VT	*A	2/82 (-)	Vermont instituted a copayment of \$1.00 for all prescription drugs. Nursing home residents are exempt.
*	VA	*A	11/83 (-)	Virginia expanded its lock-in program (previously a physician lock-in, primarily) to a full-scope program, with restrictions on the utilization of pharmacies as well. The number

of recipients participating in the program has also been increased.

VA \*A /82 (-) The Virginia legislature enacted HB 30, which imposes the following copayments on prescription drugs for all recipients:

- \$.50 per prescription of \$10 or less;
- \$1 per prescription of more than \$10.

\* WI \*A 7/83 (-) (SB 83) The Wisconsin legislature passed legislation to establish a maximum copay of \$5 per month for prescription drugs if a recipient has designated a single pharmacy from which the recipient receives all prescriptions.

### C. Reimbursement

AR \*A 7/82 (+) Arkansas increased its maximum prescription drug dispensing fee from \$3.38 to \$3.58.

CA \*P /83 (-) California proposed a prescription drug volume purchasing program to begin in January 1984. Fifty drugs were selected for inclusion in the program, and contracts were to be awarded in sixteen companies to provide these drugs. Each drug was to be supplied by between two and five different firms. The manufacturers who would have contracted with the state to provide specific drugs would return a rebate to the state for those drugs purchased by the state for Medicaid recipients. Contracts were to be awarded to those manufacturers offering the lowest net prices to the state (the current price minus the rebate). Contracts were to stipulate that rebates would increase with prices, in order to maintain the same net prices to the state during the contract period. Pharmacists would have been required to provide the designated brands of the contracted drugs to Medicaid recipients, unless another drug was prior authorized. However, this proposal will not take effect as planned.

CA \*X /82 (-) Although California received waivers for a project to design, implement, and evaluate a method of reimbursing the costs of drugs dispensed to patients in Skilled Nursing Facilities (SNFs) based on a daily capitation rate, the project was not implemented due to an insufficient number of participating SNFs.

CA	*P	/82 (-)	In California, state law reduced the drug dispensing fee by 9.6 percent, except for drugs provided to persons in skilled nursing and intermediate care facilities. However, implementation of this provision was to take effect when federal approval was obtained for the \$1 mandatory drug copayment program mandated by California law. Since the modification to the federal waiver was not approved, California has proposed a change in state law to implement the mandatory copayment.
CO	*P	1/82 (+)	The State of Colorado intends to increase pharmacy dispensing fees for medical institutions from \$1.65 to \$1.70. Government and clinic pharmacies, which now do not receive a dispensing fee, would receive \$1.70.
*	CT	*A 7/83 (-)	(SHB 5390) The Connecticut legislature enacted legislation establishing a pilot program which pays an additional \$.25 dispensing fee to a pharmacist who substitutes a generic equivalent for a prescribed drug. The additional fee is not paid if the generic substitution is required by federal law.
	CT	*A 1/82 (-)	The State of Connecticut has implemented estimated acquisition cost (EAC) pricing for prescribed drugs.
	FL	*A 7/82 (+)	The Florida legislature enacted a bill to increase professional service fees paid to retail pharmacies from \$2.75 to \$3.33 per prescription. A fee of \$1.00 is paid for each prescription dispensed by tax-supported or non-profit pharmacies.
*	GA	*A 7/83 (+)	Georgia increased its pharmacy dispensing fee from \$3.25 to \$3.61.
*	GA	*A 4/83 (+)	Georgia increased its pharmacy dispensing fee from \$3.15 to \$3.25.
*	GA	*A 5/82 (+)	Georgia increased its pharmacy dispensing fee from \$2.93 to \$3.15.
	IN	*A 1/82 (+)	Indiana established a new policy for determining the Indiana Estimated Acquisition Cost (EAC) of prescription drugs.
*	KS	*A 8/83 (-)	Kansas placed a maximum allowable cost (MAC) reimbursement limitation on Doxycycline Hyclate, both 50 mg. and 100 mg.



LA	*P	2/83 (-)	Louisiana is proposing to set state maximum allowable costs (MACs) for those drugs not covered by the established federal MAC rates.
LA	*A	10/82 (-)	Louisiana established new Maximum Allowable Costs for seven drugs.
ME	*A	1/82 (+)	The state of Maine has increased its prescription drug dispensing fee from \$2.70 to \$3.20. (It should be noted that on February 1, 1982, the state initiated a \$.50 copayment on prescription drugs.)
MD	*A	7/82 (+)	Maryland increased its rates for nursing homes, laboratories, physicians, pharmacists, dentists, medical supplies and equipment, ambulances and wheelchair vans, and medical day care.
*	MA	*A 1/82 (-)	Massachusetts no longer pays for less-than-effective drugs identified by the federal government.
*	MI	*A 7/83 (-)	(HB 4558) Michigan's Appropriations Act contains a provision that sets the maximum pharmacy dispensing fee at \$2.75.
MI	*P	4/82 (-)	The State of Michigan is considering the volume purchase of laboratory services and a manufacturer rebate plan for certain drugs.
MI	*A	3/82 (-)	Michigan changed the level of reimbursement for selected drugs by changing the quantity upon which the price is calculated.
MI	*A	/82 (-)	The state of Michigan increased the number of pharmaceutical items subject to maximum allowable cost limitations as follows:  10/81 - 5 additional MACs established; 1/82 - 5 MACs removed from coverage and 7 MACs established; 4/82 - 1 MAC removed from coverage.  Net result as of 9/82 is 80 MACs.
MI	*X	1/82 (+)	The State of Michigan proposed to restore the pharmacy dispensary fee to \$2.75. This proposal was dropped.
MN	*A	/82 (-)	Minnesota will reimburse for drugs at the actual acquisition cost of the drug plus a fixed dispensing fee.



MS	*A	7/82 (+)	Mississippi increased pharmacies' prescription drug dispensing fee from \$2.94 to \$3.17.
MO	*P	4/82 (-)	Missouri has proposed to pursue rebate arrangements based on claims volume by drug or manufacturer. The State is currently in contact with four drug manufacturers, but no agreements have yet been reached.
NE	*A	6/82 (-)	Nebraska has established a state maximum allowable charge (MAC) for certain drugs. Estimated Savings: \$100,000.
NM	*A	8/82 (-)	(HB 114) The New Mexico legislature enacted a law which allows pharmacists to prescribe equivalent drugs and which limits reimbursement to the wholesale cost of the less expensive equivalent drugs plus a dispensing fee.
*	NC	*A 7/83 (+)	(SB 23) The North Carolina legislature enacted a law which raised from \$3.00 to \$3.22 the professional services fee for dispensing prescription drugs.
	NC	*A 7/82 (+)	North Carolina increased its drug dispensing fee from \$2.80 to \$3.00.
*	OR	*A /83 (-)	Oregon added a provision making it possible to reimburse for pharmaceuticals dispensed on a unit dose or thirty-day card basis on behalf of persons in long term care facilities.
*	PA	*C /83 (-)	Pennsylvania is examining methods to control drug product cost.
	SD	*A 7/82 (+)	South Dakota increased its pharmacy dispensing fees.
	VT	*A 2/82 (+)	Vermont increased its pharmacy dispensing fee from \$2.15 to \$2.50.
	VA	*A 7/82 (-)	Virginia eliminated reimbursement for the \$.20 administrative fee for unit dose dispensed drugs.
	VA	*A 7/82 (-)	Virginia established a drug payment maximum at the 75th percentile of the range listed in the Virginia formulary.
	VA	*A /82 (-)	The Virginia legislature enacted HB 30, which limits payment to one dispensing fee per month for each legend drug dispensed to nursing home recipients.

\* WA \*A /83 (-) The state of Washington established a Maximum Allowable Cost (MAC) for generically clustered drugs.

WA \*A 2/82 (-) The State of Washington implemented an Estimated Acquisition Cost reimbursement system for prescription drugs.

## 21. Family Planning Services

### A. Amount, Duration and Scope

- \* HI \*A 11/83 (-) Hawaii eliminated family planning services for adults receiving General Assistance (state only funds).

### B. Utilization Controls

### C. Reimbursement

- \* ME \*A 10/83 (+) Maine increased its reimbursement rates for family planning agency services.

## 22. EPSDT Services

### A. Amount, Duration and Scope

- \* AL \*A 7/83 (-) Within a calendar year each Alabama Medicaid recipient is now limited to no more than a total of twelve physician visits in any combination of office, hospital outpatient, or nursing home settings. Visits counted under this quota will include, but not be limited to, visits for: prenatal care, postnatal care, family planning, second opinions, consultations, referrals, EPSDT referrals, immunizations, injections, psychotherapy, physical therapy and care by ophthalmologists for eye disease.

Physician hospital visits do not count toward this limit: recipients hospitalized are entitled to the physician visits that are medically necessary during the hospital days that are paid for by Alabama Medicaid.

Psychiatric evaluation or testing, psychotherapy visits, group therapy and family therapy visits are counted as part of the yearly quota of 12 visits for each recipient.

Ancillary services when performed by a physician, or under his supervision, can be billed by the physician without counting an office visit. (Example: drug injection, laboratory and x-ray.)

- MA \*A 3/82 (+) Massachusetts established regulations for family planning agencies to provide "Project Good Health" (EPSDT) assessments. (Contact: Lynne Karsten 617/727-8084.)
- NV \*A 3/82 (-) Nevada reduced its periodicity schedule from 12 to 10 screenings for EPSDT recipients.
- \* OK \*A 4/83 (+) Oklahoma's EPSDT program was enhanced. Services will include: scheduled child health screenings by a licensed medical or osteopathic physicians at 12 months, 4 years, 6 years, 10 years, and 16 years. Well-child checkups are allowed for newborns and six times during the first year, three times during the second year, once during the third year, and yearly thereafter except for the years in which there are scheduled screens.



OR \*A 1/82 (-) Oregon revised EPSDT dental services by limiting visits to a periodicity schedule, by establishing priorities for care and by requiring prior authorization for non-emergency services.

WI \*A 3/82 (-) Wisconsin eliminated the EPSDT outreach program, which was provided through outreach agencies, and instituted coverage of case management/screening services.

## B. Utilization Controls

## C. Reimbursement

\* MD \*A 5/83 (+) Maryland increased its fees for EPSDT screenings provided by physicians, HMOs, children and youth clinics, and local health departments.

\* MO \*A 1/83 (+) Missouri increased the fee for EPSDT screenings from \$25 to \$28.

WI \*A 3/82 (-) Wisconsin eliminated the EPSDT outreach program, which was provided through outreach agencies, and instituted coverage of case management/screening services. EPSDT fees were decreased from \$28 to \$10 per visit.

## 23. Other Diagnostic, Screening and Preventive Services

### A. Amount, Duration and Scope

- MD \*A 2/82 (+) The State of Maryland has been granted waivers to establish a center for teenage mothers and infants to provide quality medical care, psychosocial services, and health education services during pregnancy, labor, delivery and the neonatal and postpartum periods. These services will be based on application of the concept of early and periodic screening and followup for diagnosis and treatment, with a heavy emphasis on prevention through appropriate intervention measures and health education. Family planning is a major thrust since the health of the young mother and child is at risk.
- \* NE \*P /83 (+) Nebraska proposes to increase its CT scan coverage to correspond to Medicare's coverage.
- SC \*A 1/82 (-) South Carolina ceased coverage of immunizations, with the exception of the EPSDT program.

### B. Utilization Controls

### C. Reimbursement

## 24. Rehabilitative Services

### A. Amount, Duration and Scope

- LA \*A 5/82 (+) Louisiana added coverage of rehabilitative services provided by centers for the mentally retarded. These services are designed to develop personal, social, and employment skills. Six to eight hours of training are provided.
- LA \*A 5/82 (+) Louisiana began providing adult day health care services for individuals who might otherwise be institutionalized.
- \* MN \*A /83 (+) The Minnesota legislature added vision care and Medicare-certified rehabilitation agency services to its General Assistance Medical Care Program (GAMP), a state-only funded program.
- NJ \*P 2/82 (+) (S 792) The New Jersey legislature reports the introduction of a bill to expand coverage of alcoholism treatment.

### B. Utilization Controls

- IA \*A 4/82 (-) Iowa instituted a \$2.00 copayment on rehabilitative services for total covered service rendered on a given date.
- UT \*A 9/82 (-) Utah began requiring prior authorization for rehabilitative physical therapy services provided through home health service providers, when these treatments exceed ten per incident.

### C. Reimbursement

- \* AK \*A 7/83 (-) (SB 85) The Alaska legislature enacted a law which established the Medicaid Rate Commission to set prospective payment rates for all health facilities, including: hospitals, SNFs, ICFs, ICFs/MR, rehabilitation facilities, inpatient psychiatric facilities, home health agencies, rural health agencies, and outpatient surgical clinics.
- KS \*A 7/82 (-) Kansas set maximum reimbursement levels for geriatric, psychiatric, alcohol and drug day treatment and for psychiatric partial hospitalization. Future payment levels will increase by a negotiated inflation factor.

MD \*A 7/82 (+) Maryland increased its rates for nursing homes, laboratories, physicians, pharmacists, dentists, medical supplies and equipment, ambulances and wheelchair vans, and medical day care.

NH \*C /82 (-) The State of New Hampshire is considering changing its reimbursement approach for rehabilitation centers from a negotiated fee based on reasonable cost to a flat fee-for-service.



## 25. Transportation Services

### A. Amount, Duration and Scope

- CA \*P /82 (-) The California legislature enacted a law which would limit the provision of nonemergency medical transportation services to those patients requiring continuing medical care such as dialysis, chemotherapy, or radiation therapy in order to prevent a life-threatening situation. Transportation also could be authorized to transport patients between long term care facilities and hospitals, between long term care facilities and necessary outpatient service sites, between acute or long term care facilities and the patient's home, or between two long term care facilities in the event a facility is closing. Basically, this would eliminate the majority of nonemergency medical transportation from a place of residence to medical care. This change has not been implemented and is suspended at this time due to court action.
- \* NH \*A 7/83 (+) New Hampshire raised its limits on wheelchair van trips from 12 to 24 trips per recipient per year.
- OR \*A 2/82 (-) Oregon established priorities for non-emergency transportation. That is, it defined those situations in which it would pay for transportation and those in which it would not but would find alternate sources. Non-emergency transportation must be pre-authorized and documented as medically necessary. A class action suit was immediately filed against this policy. Subsequent discussions led to a consent decree which will allow Oregon to continue using its priority system; however, it will no longer deny payment for certain services.
- RI \*A 5/82 (-) Rhode Island eliminated payment for ambulance services for medically needy only recipients.
- \* VA \*A 7/83 (-) (SB 30) The Virginia legislature enacted a law which established the Registered Driver Program that requires the recipient to use the most economical transportation to obtain services. Under this program the recipient must recruit a registered provider. Reimbursement is set at \$.20 per mile with no "waiting time" allowance. Immediate family members are not eligible for payment.

## B. Utilization Controls

- CA \*X 1/82 ( ) The California legislature reports introduction of two bills to eliminate prior authorization for certain non-emergency medical transportation costs. AB1427 would exempt those costs under \$50.00, and AB1428 would exempt transportation to a recipient's residence or to a lower-cost facility. These bills did not pass.
- CT \*X /82 (-) Connecticut applied for a freedom of choice waiver to impose a \$1 copayment (higher than federal regulations allow) on medical transportation (taxi and livery) and to exempt frequent users of such transportation. The waiver request was disapproved by HCFA on March 2, 1982, and this proposal was dropped.
- \* CT \*A /82 (-) The Connecticut legislature enacted a law to impose a \$.50 copayment for taxi usage by Medicaid recipients (the maximum amount allowed by HCFA). Regulations are pending.
- IA \*A 4/82 (-) Iowa instituted a \$2.00 copayment on ambulance services.
- \* MS \*A 11/82 (+) Mississippi eliminated its \$3 copayment on ambulance services.
- MO \*A 5/82 (-) Missouri began conducting pre-payment reviews of all ambulance claims to ensure that only emergency ambulance claims are paid (no routine transfers); that transports beyond 70 miles are justified; that the destination is a hospital; and that multiple transfers are reviewed for necessity. This option is supported by the Ambulance Subcommittee of the state's Medical Advisory Committee.
- VA \*A /82 (-) The Virginia legislature enacted HB 30, which imposes the following copayments on prescription drugs for all recipients:
- \$.50 per prescription of \$10 or less;
  - \$1 per prescription of more than \$10.

### C. Reimbursement

- CT \*X 2/82 ( ) (H 5428) The Connecticut legislature reported introduction of a bill to reimburse ambulance service at the Medicare rate. This proposal was dropped.
- LA \*A 10/82 (-) Louisiana changed the designation of providers of non-emergency transportation from "regular" provider to "profit" provider in order to distinguish between profit and non-profit providers and to incorporate rates and manner of reimbursement for profit and non-profit organizations and individuals providing non-emergency transportation services under Title XIX.
- MD \*A 7/82 (+) Maryland increased its rates for nursing homes, laboratories, physicians, pharmacists, dentists, medical supplies and equipment, ambulances and wheelchair vans, and medical day care.
- \* NH \*A 7/83 (+) New Hampshire raised its reimbursement rate for private vehicle/volunteer transportation from \$.17 to \$.25 per mile.
- \* NH \*A 1/83 (+) New Hampshire dropped its reimbursement on private transportation of \$10 for a one-way trip and \$20 round-trip.
- \* NC \*A 7/83 (-) (SB 23) The North Carolina legislature enacted a law which reimburses ambulance services at 100 percent of allowable, reasonable, usual and customary charges subject to 7 percent limit on rate increases.
- \* TN \*P 10/83 ( ) For a number of services and goods, including physician and dentist services, ambulance services, and supplies; Tennessee is proposing to upgrade its reimbursement rates (based on usual and customary charges), by changing its base year from CY1980 to CY1982. In 1982 the rates were not upgraded due to technical problems; in lieu of upgrading, the state raised its rates from 90 percent to 95 percent of reasonable charges. Therefore, when the rates are upgraded, it is anticipated that the percentage will be lowered.



## 26. Eyeglasses

### A. Amount, Duration and Scope

- CA \*A 9/82 (-) The California Legislature limited coverage of eyeglasses to patients whose eyeglasses have a refractive correction of at least 1.00 diopter. Similarly, the minimum amount of change in power to qualify for coverage of new eyeglasses is being increased. (Some beneficiaries who experience eyestrain, mild headaches, or slightly blurred vision may not be covered.) Obtaining an automobile driver's license should not be affected. A reduction of 20-25 percent in the number of eyeglasses supplied under Medi-Cal is projected.
- \* HI \*A 11/83 (-) Hawaii tightened the limitation on eyeglasses from one pair a year to one pair every two years. Eyeglasses may be obtained more often with prior authorization and documentation of medical necessity.
- IL \*A /82 (-) Illinois began limiting coverage of eyeglasses to one pair every two years for adults between the ages of 19 and 40 years, with certain exceptions.
- \* KS \*A 5/83 (-) Kansas reduced coverage of eye examinations and eyeglasses to one every four years. As before, exceptions to the eye exam limitation include EPSDT participants and those with medical conditions requiring more frequent exams by an ophthalmologist. EPSDT participants may receive eyeglasses more frequently; however, the second and subsequent pairs within four years must be pre-authorized. In addition, eyeglasses are covered for recipients within one year of cataract surgery.
- ME \*A 7/82 (-) Maine modified its coverage of eyeglasses in the following ways: (1) it will not cover prescription sunglasses, tinted lenses or photochromic lenses unless the provider submits a statement that they are medically necessary due to the presence of photophobia or an abnormal tolerance of light; (2) the state will not cover oversize lenses, high-cost fashion frames, fashion tints or other ophthalmic supplies which serve only a cosmetic purpose; (3) when eyeglass frames are damaged but the lenses are still serviceable, only the frames will be replaced.



MO \*A 5/82 (-) Missouri discontinued coverage of replacement eyeglasses. One pair of eyeglasses is allowed every two years. Replacement of lenses is covered for a 0.50 diopter change only.

NM \*A 7/82 (+) New Mexico implemented a policy that it will provide monocular aphakics with one contact lens and a pair of bifocal glasses. Bilateral aphakics may be provided a pair of aphakic lenses only.

NM \*A 7/82 (-) New Mexico limited payment for eyeglass frames to \$15.00. It also limited reimbursement for glasses to once every two years, with exceptions for persons with cataracts or children under 16 with severe progressive myopia. Tinted and photogray lenses are not covered.

OR \*A 2/82 (-) Oregon limited coverage of eyeglasses to one pair in 24 months.

RI \*A 5/82 (-) Rhode Island dropped coverage of eyeglasses for its medically needy only recipients.

\* VT \*P 10/83 (-) Vermont is proposing to reduce coverage of eyeglasses from a maximum frequency of one pair every year to one pair every two years.

VA \*A 7/82 (-) The Virginia legislature enacted HB 30, which eliminates the purchase or repair of eyeglasses, except for the categorically needy when this results from an EPSDT screening.

WV \*A 1/82 (-) West Virginia eliminated coverage of eyeglass cases.

WV \*A 1/82 (-) West Virginia eliminated coverage of eyeglasses and examinations for eyeglasses for recipients over 21 years of age.

#### **B. Utilization Controls**

IA \*A 4/82 (-) Iowa increased its copayment for optometric services from \$1.00 to \$2.00 for total covered service rendered on a given date.

ME \*A 7/82 (-) Maine began requiring prior authorization for any eyeglass frames which exceed Medicaid's maximum allowance. Clinical justification must be documented. Without pre-authorization, eyeglasses will not be covered in whole or in part.

\* MS \*A 11/82 (+) Mississippi eliminated its \$3 copayment on eyeglasses.

**C. Reimbursement**

IA \*P /83 (-) The state is considering a proposal to enter into arrangements for the bulk purchase of optometric supplies.

MS \*A 7/82 (+) Mississippi increased fees for eyeglass services by 7.8%.

NM \*A 7/82 (-) New Mexico limited payment for eyeglass frames to \$15.00. It also limited reimbursement for glasses to once every two years, with exceptions for persons with cataracts or children under 16 with severe progressive myopia. Tinted and photogray lenses are not covered.

WI \*A 4/82 (-) The State of Wisconsin implemented a volume purchase plan for eyeglasses, effective April 1982.

## 27. Hearing Aids

### A. Amount, Duration and Scope

- \* HI \*X /83 (-) Hawaii proposed a lifetime ceiling on coverage of hearing aids to \$300.00 per person. However, this proposal was dropped.
- \* LA \*P /83 (-) Louisiana proposes to eliminate coverage of hearing aids, batteries and repairs for non-EPSDT eligibles.
- MO \*A 5/82 (-) Missouri began allowing only one audiological examination for a hearing aid every four years unless a Medical Necessity Form is attached and completed properly and approved by the Medicaid Consultant. This measure is endorsed by the Audiology Subcommittee of the state's Medical Advisory Committee.
- NY \*P 2/82 (+) (A 9975) The New York legislature reports the introduction of a bill to provide hearing aids to deaf persons.
- OR \*A 1/82 (+) Oregon added coverage for adults of hearing aid services provided by audiologists and hearing aid dealers.

### B. Utilization Controls

- IA \*A 4/82 (-) Iowa increased its copayment from \$1.00 to \$3.00 for hearing aids.
- \* KS \*A 8/83 (-) Kansas began requiring that all hearing aids be prior authorized. Replacement aids will be covered only once in four years. If hearing aids are lost, broken or destroyed, they may be replaced once during the four-year period, when prior authorized.
- \* KS \*A 8/83 (+) Kansas raised the ceiling on hearing aid repairs allowed without prior authorization from \$65 to \$75.
- \* MI \*A 7/83 (-) (HB 4558) Michigan's Appropriations Act requires the Department of Social Services to impose copays on dental, podiatric, vision, chiropractic and hearing aid services for recipients over 21 years of age.
- MI \*X 1/82 (-) The State of Michigan proposed to impose a \$.50 copayment on each hearing aid battery provided to a recipient. This proposal has been dropped.

MI \*A 1/82 (-) Michigan implemented a copayment of \$3.00 on hearing aids for Title XIX recipients 21 and older and for all General Assistance recipients.

**C. Reimbursement**

CA \*A 9/82 (-) California reduced fees for fitting and dispensing hearing aids by ten percent. In addition, replacement hearing aid batteries were dropped as a covered benefit.

IA \*P /83 (-) The state is considering a proposal to enter into arrangements for the bulk purchase of hearing aids.

KS \*X /82 (-) The state of Kansas proposed to enter into an arrangement for the bulk purchase of hearing aids. This proposal has been dropped.

MI \*X /82 (-) The State of Michigan was considering the volume purchase of hearing aids. However, the hearing aid proposal has been dropped.

MO \*A 5/82 (-) Missouri began allowing only one hearing aid dispensing fee per person (not a dispensing fee for each hearing aid for both ears if two hearing aids are medically needed).

NJ \*A 4/82 (-) The State of New Jersey changed, effective April 1, 1982, the method of reimbursement for hearing aids from manufacturers' list price less 20% to a single unit cost plus a dispensing fee. (Contact: Sanford Luger, Chief, Bureau of Pharmaceutical Services 609/292-3756).

ND \*C 6/82 (-) North Dakota is considering a competitive bidding process for the purchase of hearing aids.



## 28. Dentures

### A. Amount, Duration and Scope

KY	*A	1/82 (-)	Kentucky eliminated coverage of bridgework for individuals 21 and under.
KY	*A	1/82 (-)	Kentucky eliminated coverage of upper and lower dental plates for all ages.
KY	*A	1/82 (-)	Kentucky discontinued coverage of dentures.
MO	*A	5/82 (-)	Missouri requires that all participating dentists meet certain criteria when providing dentures.
MO	*A	5/82 (-)	Missouri began disallowing payment for denture adjustments and denture rebases when either or both services occur within six months of the date dentures were placed. This policy was recommended by the Dental Subcommittee of the State's Medical Advisory Committee.

### B. Utilization Controls

MO	*A	5/82 (-)	Missouri established more stringent guidelines on the prior authorization of dentures.
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### C. Reimbursement

## 29. Prosthetic Devices

### A. Amount, Duration and Scope

- AK \*A 7/82 (+) Alaska added coverage of prosthetic devices. Previously, these were provided solely to state-only funded individuals.
- \* KY \*A 11/82 (+) In Kentucky, prosthetic and orthodontic coverage was reinstituted for recipients under age 21, retroactive to January 1, 1982. This includes all previously covered procedures in these two categories except complete dentures and full mouth braces (coverage had been deleted in January 1982).
- NJ \*X /83 (+) New Jersey had proposed to recognize qualification for Veterans Administration as a criterion for Medicaid approval of prosthetic and orthotic providers. This proposal was dropped.
- \* SC \*A 7/82 (-) South Carolina will not add coverage of any additional prosthetic or orthotic devices after July 1982, even if these devices are added to the Medicare program.

### B. Utilization Controls

- IA \*A 4/82 (-) Iowa increased its copayment from \$1.00 to \$2.00 for orthopedic shoes.
- MO \*A 11/82 (-) Missouri began requiring prepayment review of all claims for DME, prosthetics, and orthotics.
- NE \*A 8/82 (-) Nebraska began imposing prior authorization requirements for provision of orthopedic shoes, corrections, braces and other supplies or items for the feet which exceed \$50 in cost. The county will prior authorize items costing between \$50 and \$200; the state will have prior authorization responsibilities for items over \$200.
- \* SD \*A 7/83 (-) South Dakota imposed recipient cost-sharing of five percent of the allowable reimbursement for each prosthetic device billed.

### C. Reimbursement

- MO \*A 12/82 (+) Missouri increased fees for certain DME, prosthetic, and orthotic devices and equipment.

### 30. Durable Medical Equipment and Supplies

#### A. Amount, Duration and Scope

- AK \*A 7/82 (+) Alaska added coverage of medical supplies. Previously, these were provided solely to state-only funded individuals.
- CO \*C /83 (-) Colorado is considering a change in its durable medical equipment (DME) program in which the state would retain ownership of DME. Contracts would be signed with various providers around the state to monitor use of equipment, collect it when it is no longer needed, store it, refurbish it and distribute it. Currently, DME becomes the property of the recipient.
- CT \*X /82 (-) The State of Connecticut considered limiting reimbursable durable medical equipment and supplies to those covered by Medicare. Presently, it covers a wider range of items. This proposal was dropped.
- \* KS \*A 8/83 (-) Kansas implemented a policy of limiting coverage of certain durable medical equipment (DME) items to recipients living at home. (These items are furnished to residents of adult care homes by the homes.)
- \* KS \*A 5/83 (-) Kansas limited coverage of the rental or purchase of DME to:
- Participants in EPSDT,
  - Recipients who require the DME for life support,
  - Recipients who require the DME for employment, and
  - Recipients who would require higher cost care if the DME was not provided.
- \* KS \*A 1/83 (-) Kansas eliminated coverage of many DME items--either their rental or purchase of both. Most of the DME items which are still covered now require prior authorization.
- \* KS \*A 6/82 (+) Kansas began covering the rental of portable oxygen vessels (E tank cylinders) and the purchase of oxygen for the E cylinder. There is a limitation of two tanks per month per recipient, and medical necessity must be documented.

- KS \*A 6/82 (-) Kansas implemented a new DME policy: electric wheelchairs and beds will be rented rather than purchased. However, some purchases of used equipment will be authorized. Many wheelchair accessories and other related items will no longer be covered.
- KS \*A 3/82 (+) Kansas began covering rental of oxygen concentrators for residents of adult care homes when the cost of oxygen in cylinders and the rental of the cylinders exceeds the monthly rental cost of the concentrator.
- LA \*A 7/82 (+) Louisiana implemented reimbursement to providers for hyperalimentation therapy.
- MO \*P /82 (-) Missouri has proposed to limit DME Medicare/Medicaid crossover claim payments to only those items that are covered by the state Medicaid program.
- NJ \*A /83 (-) New Jersey initiated a policy that lease costs incurred as a result of a related party will not be reimbursable.
- \* SC \*A 7/82 (-) South Carolina will not add coverage of any additional durable medical equipment and/or medical supplies after July 1982, even if these items are added to the Medicare program.
- WI \*A 12/82 (-) Wisconsin implemented a DME index which limits coverages, institutes reimbursement maximums and outlines prior authorization requirements for durable medical equipment.

#### **B. Utilization Controls**

- \* GA \*A 11/82 ( ) In Georgia, as of November 1982, prior approval for DME purchases will be required only on items in excess of \$200.00.
- \* GA \*A 11/82 ( ) In Georgia, as of November 1982, prior approval for Durable Medical Equipment repairs is required only on total repair costs in excess of \$200.00.
- IA \*A 4/82 (-) Iowa increased its copayment from \$1.00 to \$2.00 on medical equipment and supplies for total covered service rendered on a given date. Sickroom supplies will no longer be exempted from this copayment.



- \* KS \*A 8/83 (-) Kansas deleted its prior authorization requirement for a number of durable medical equipment items.
- \* ME \*A /83 (-) Maine completely revamped its policies regarding Medical Supplies and Durable Medical Equipment. Among the changes were requirements that all rentals be pre-authorized, and that any purchase in which the adjusted acquisition cost is over \$100 also be pre-authorized. The method of reimbursement was also changed (see Reimbursement Section).
- MO \*A 11/82 (-) Missouri began performing pre-payment review of all DME claims to determine if necessary attachments are present, if a justified diagnosis is present, if the equipment should be purchased or rented, etc.
- OR \*A 10/82 (-) Oregon dropped requirement for prior authorization for certain medical supplies.
- \* SD \*A 7/83 (-) South Dakota imposed recipient cost-sharing of \$1.00 for each medical supply billed and five percent of the allowable reimbursement for each item of medical equipment.
- WI \*A 12/82 (-) Wisconsin implemented a DME index which limits coverages, institutes reimbursement maximums and outlines prior authorization requirements for durable medical equipment.

### C. Reimbursement

- \* CO \*C /83 (-) Colorado is considering a change in its reimbursement for disposable medical supplies from a flat rate to a rate based on the manufacturer's cost.
- \* GA \*A 11/82 (-) Georgia limited all reimbursement for durable medical equipment to the new Medicare rates.
- IA \*A 4/82 (-) Iowa has adopted a measure mandating purchase of used equipment when available and appropriate.
- KS \*C 1/83 (-) Kansas is considering awarding a contract, possibly through a competitive bidding process, for administration of a wheelchair loan closet. Wheelchairs would be retrieved, reconditioned, stored and reissued to adult care home residents in order to reduce the number of new wheelchairs purchased.

KS	*C	/82 (-)	Kansas is considering the bulk purchase of durable medical equipment, medical supplies, and dentures. (In 1982 volume purchase of wheelchairs was considered and rejected.)
ME	*A	12/83 (+)	The state of Maine changed its method of reimbursing for durable medical equipment and medical supplies. Payment was previously based on a pre-determined maximum allowance which did not reflect changes in the cost of the goods. The new method of calculating the maximum allowance takes into account the cost of the goods to the provider and adds a 30 to 50 percent markup, depending upon the cost of the item.
MD	*A	7/82 (+)	Maryland increased its rates for nursing homes, laboratories, physicians, pharmacists, dentists, medical supplies and equipment, ambulances and wheelchair vans, and medical day care.
MO	*A	12/82 (+)	Missouri increased fees for certain DME, prosthetic and orthotic devices and equipment.
*	NE	*P /83 (-)	Nebraska is proposing a major DME revision, including expansion of procedure codes and a change in the payment methodology from paying billed charges to usual, customary and prevailing charges. It is targetted for early 1984.
NV	*A	1/82 (-)	The State of Nevada has reinstituted a statewide inventory system for durable medical equipment which the state has purchased and provided to Medicaid recipients.
*	NC	*A 7/83 (-)	(SB 23) The North Carolina legislature enacted a law which mandates reimbursement of optical supplies at 100 percent of reasonable wholesale cost of materials.
SC	*A	2/82 (-)	South Carolina adopted fee schedules for dental care, vision care and durable medical equipment. The previous method of reimbursement was fee-for-service at usual and customary rates.
*	TN	*P 10/83 ( )	For a number of services and goods, including physician and dentist services, ambulance services, and supplies; Tennessee is proposing to upgrade its reimbursement rates (based on usual and customary charges), by changing its base

year from CY1980 to CY1982. In 1982 the rates were not upgraded due to technical problems; in lieu of upgrading, the state raised its rates from 90 percent to 95 percent of reasonable charges. Therefore, when the rates are upgraded, it is anticipated that the percentage will be lowered.

WA \*A 7/82 (-) Washington entered an exclusive contract with one statewide supplier for the provision of oxygen and respiratory therapy.

WI \*A 12/82 (-) Wisconsin implemented a DME index which limits coverages, institutes reimbursement maximums and outlines prior authorization requirements for durable medical equipment.

## LONG TERM CARE SERVICES

### 31. SNF/ICF Services

#### A. Amount, Duration and Scope

CA	*A	9/82 (-)	California increased paid leave days for nursing home patients in certain programs for the mentally disordered from 18 to 30 days per year, separately defined "bed holds" as days when patients are in acute care facilities, and reduced reimbursement for all leaves and "bed holds" by \$2.47 per day.
CO	*X	9/82 (+)	Colorado planned to implement a state-only funded Nursing Home Patient Improvement Fund, which would have allowed the state to provide front-end funding (specific budgeted amounts) for certain patient care enhancement items. The fund was provided for in House Bill 1288. However, the proposal was dropped.
CT	*X	/82 (-)	The State of Connecticut considered elimination of coverage for reserved bed days in nursing homes. This proposal has been dropped.
CT	*X	/82 (-)	The State of Connecticut considered waiving, for nursing homes, certain requirements which were implemented in October 1981 as a part of the revision of the state's public health code. This proposal was dropped.
DE	*A	8/82 (+)	Delaware added ICF services for individuals over age 65 in IMDs.
DC	*A	6/83 (+)	The District of Columbia eliminated its ceiling on the number of allowable nursing hours for patients in SNFs and ICFs.
*	ID	*A /83 (+)	(SCR 106) The Idaho legislature enacted a law to reinstate coverage of reserved bed days in nursing homes having less than five unoccupied beds or greater than 95 percent occupancy rate, limited to three days per absence, 15 days a year.
	ID	*A 9/82 (-)	Idaho eliminated coverage of reserve bed days for nursing home patients during leaves of absence.
*	IL	*A 9/82 ( )	Illinois added coverage of influenza vaccines for nursing home residents.



- \* IL \*A 10/83 ( ) Illinois added coverage of hepatitis B serum for nursing home residents.
- \* KS \*A 5/83 (-) Kansas reduced the limitation on administrative leave days for residents of adult care homes from 15 to ten days during a hospitalization. The therapeutic leave (or home reserve days) limitation will continue to be 18 days for ICF, ICF/MI and SNF residents and 30 days for ICF/MR residents.
- \* KS \*A 10/82 (-) Kansas ceased coverage, through Medicaid, of flu vaccine for residents of adult care homes (nursing homes). (All residents of nursing homes, regardless of Medicaid status, are eligible for a voluntary flu vaccine program administered by the Kansas Department of Social and Rehabilitation Services.)
- KS \*A 7/82 (+) Kansas established coverage of care for recipients 16 years and older with a primary diagnosis of mental illness in ICFs for Mental Health (previously known as ICFs for the mentally ill). These facilities were developed in 1982, and many of their residents were formerly residents of general ICFs.
- \* MA \*A /83 (-) (H 6785) The Massachusetts legislature enacted legislation to authorize nurse practitioners and physician assistants to issue prescriptions to patients in long term care facilities and chronic patients in home care settings.
- \* MI \*A 7/83 (-) (HB 4558) Michigan's Appropriations Act contains a provision to eliminate funds for hospital leave days.
- \* MI \*A /83 (-) Michigan applied for and received a Section 2176 home- and community-based long term care model waiver in order to provide alternative services for up to fifty severely disabled children who have been receiving institutional care, and who would otherwise not qualify for Medicaid coverage of non-institutional care due to income-deeming rules.
- \* MN \*A 6/83 (+) (SF 1234) The Minnesota legislature enacted a law which increased from 10 days to 30 days the maximum length of stay reimbursable to hospitals and nursing homes for treatment of alcoholism, chemical dependency, or drug addiction.

*	NE	*A	10/83 (+)	Nebraska began allowing payment for one day of care when a client dies on the day of admission to a long term care facility.
	NJ	*P	/83 (+)	The New Jersey legislature reports the introduction of bills to require nursing homes to reserve beds for up to 7 or 14 days, when residents are temporarily hospitalized.
	NJ	*A	9/82 (-)	New Jersey began providing pediatric long term care.
	NJ	*P	2/82 (-)	(S 511) The New Jersey legislature reports the introduction of a bill to permit hospitals to establish swing beds.
	NJ	*C	/82 (-)	New Jersey is considering recognizing only one level of ICF care in order to save on administrative costs.
*	OH	*P	11/83 (+)	Ohio is proposing to expand coverage of nursing home (SNF and ICF) leave days, for either hospitalization or therapeutic purposes, to 30 per year.
*	OH	*P	11/83 ( )	Ohio is proposing a rule which would require nursing homes to reserve a patient's bed for up to 24 days while the patient is hospitalized, regardless of whether or not the patient has used up his or her allowed number of leave days. (Leave days may be used for either hospitalization or therapeutic leave, and it is hoped that patients will not refuse therapeutic leave in fear of losing their beds during hospitalizations.)
*	OH	*A	7/83 (+)	(HB 291) The Ohio legislature enacted a law which rescinded the reduction in nursing home leaves of absence mandated by HB 100. This law returned the number of allowed leave days to 24 per year.
*	OH	*A	7/83 (-)	(HB 100) The Ohio legislature enacted a law which reduced the limit on nursing home leave days from 24 to 14 per year. (This was subsequently rescinded by HB 291.)
	PA	*A	1/84 (-)	Pennsylvania is implementing a policy to deny payment to nursing homes not participating in Medicare or for patients, from day 21 through day 80, who were in non-Medicare-certified beds for the Medicare benefit period.

PA \*A /82 ( ) Pennsylvania modified its policy regarding leaves of absence from nursing homes for hospitalization. The facilities will now be reimbursed one-third of the nursing home interim rate for these leave days. The limit of 15 days per leave of absence remains.

RI \*P /83 (-) Rhode Island has submitted an 1115 waiver in order to establish a distinct group of medically needy individuals whose incomes are at or below \$1,500 and who are in need of ICF care. ICF services would be provided only to this group of medically needy. An earlier attempt to implement this policy through a state plan amendment was disapproved by HCFA.

SD \*C /82 (-) South Dakota is considering a reduction in the number of days for which beds may be reserved for nursing home patients on leave. The current limit is ten days for hospitalization. There is no limit for therapeutic home visits.

\* UT \*A 5/83 (-) Utah limited coverage of day treatment for nursing home patients by ending these benefits 90 days prior to discharge from the nursing home. (This avoids duplicative coverage since nursing homes are required to provide such services in the 90 days prior to discharge in order to prepare the patient for living outside of the institution.)

VA \*A /82 (-) Virginia implemented more restrictive criteria for ICF eligibility.

WV \*A 1/82 (-) West Virginia ceased coverage of nursing home bed reservations during recipient absences.

WI \*A 11/83 (-) Wisconsin removed exceptions policies which had allowed coverage for certain new admissions to ICFs, levels III and IV (which provide services that are not primarily medical in nature). In October 1981, coverage of new admissions into ICFs III and IV was dropped, with several exceptions. The exceptions have now been removed in order to meet federal comparability of services requirements. Only those recipients who entered ICFs III and IV prior to October 1, 1983 and have resided there continuously will continue to be covered.



## B. Utilization Controls

- \* AL \*A 10/82 (-) The administration of prior authorization for coverage of ICF services was shifted from the PSRO to the Alabama Medicaid Agency.
  
- \* CT \*C /83 (-) The Connecticut Medicaid agency is considering the implementation of a nursing home pre-admission screening program.
  
- CT \*X 2/82 (-) (H 5355) The Connecticut legislature reported a bill to create a mandatory pre-screening program for persons leaving a hospital prior to entering a nursing home. This proposal has been dropped.
  
- \* IL \*A 9/83 (-) Illinois implemented pre-screening of nursing home applicants.
  
- \* IL \*C /83 (-) Illinois is considering the establishment of Drug Utilization Review for long term care facility residents.
  
- IN \*A 7/82 (-) (HB 1304) The Indiana legislature enacted in July 1982 a bill to establish a LTC pre-admission screening program. The State Department of Public Welfare implemented the program statewide on April 30, 1983. Special features include screening of private pay applicants and screening of all applicants who will be expected to be Medicaid-eligible within one year from nursing home entry.
  
- LA \*A 2/83 (-) Louisiana modified its state regulations so that physicians are no longer required to make routine medical visits every 60 days to their patients in ICF facilities provided that, in their opinions, the visits are not medically necessary.
  
- MI \*A 1/82 (-) The Michigan Medicaid program began allowing nurse practitioners to recertify inpatient stays for hospitals and nursing homes.
  
- MN \*A /82 (-) Minnesota initiated a preadmission screening program for Medicaid recipients seeking admission to SNFs and ICFs. Alternative community care, if no more costly, is offered as an option.



- \* NH \*X /83 (-) (HB 728) The New Hampshire legislature considered a bill to establish a mandatory nursing home pre-admission screening program for Medicaid eligibles and persons who may become eligible for Medicaid within 6 months of applying for admission to a nursing home. This proposal did not pass.
  
- NJ \*A 9/82 (-) New Jersey reduced the frequency of long term care level of care assessments to every six months for SNFs and once a year for ICFs.
  
- PA \*A 11/83 (-) Pennsylvania implemented, on a limited demonstration basis in several counties (more counties are gradually being phased in), requirements that individuals undergo assessment prior to receiving long term care, in order to increase community-based long term care.
  
- \* PA \*A /82 (-) Pennsylvania is one of a limited number of states participating in a HCFA channelling demonstration project. Known as "The Philadelphia Project," the program consists of pre-admission assessment for persons applying for entrance into nursing homes, and for a formal evaluation of the program at a later date.
  
- SC \*A 1/82 (-) In South Carolina the Community Long Term Care project (CLTC) does pre-admission review and level of care certification for long term care. The Department of Health and Environmental Control (DHEC) does inspection of care. Nursing home utilization review committees are responsible for continued stay review.
  
- WI \*P 2/82 (-) Wisconsin has requested a federal waiver to modify its LTC utilization control and survey and certification processes. The modifications sought have already been validated through a four-year 1115 demonstration. The plan would reduce the paperwork burden on nursing home operators and state and federal staff, allow more flexibility in the timing of inspections and afford a more realistic policy for plans of correction. (Anticipated annual savings: \$6 million.) The initial waiver was denied, but the state will continue to seek approval.

### C. Reimbursement

- \* AL \*X 2/82 ( ) (S. 58) The Alabama legislature reported the introduction of a bill to create a Pediatric and Long Term Care Commission which would be responsible for establishing Medicaid nursing home reimbursement rates. This bill did not pass.
- \* AL \*A 1/82 (-) Alabama rewrote its nursing home reimbursement regulation manual, revising the state's LTC reimbursement methodology to use rates that are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities. The methodology is now totally prospective. The state now maintains two 60th percentile ceilings: one is on the administration and management cost center, and one is on the overall budget for the facility. Alabama anticipates that the percentage increase in state nursing home expenditures will drop as a result of this change in methodology.
- \* AK \*A 7/83 (-) The Alaska legislature enacted a law mandating prospective reimbursement for hospitals and nursing homes. The agency must promulgate regulations before implementation, which is scheduled for the latter part of 1983.
- \* AK \*A 7/83 (-) (SB 85) The Alaska legislature enacted a law which established the Medicaid Rate Commission to set prospective payment rates for all health facilities, including: hospitals, SNFs, ICFs, ICFs/MR, rehabilitation facilities, inpatient psychiatric facilities, home health agencies, rural health agencies, and outpatient surgical clinics.
- \* CA \*A 8/83 (-) California reduced reimbursement rates to nursing homes for all leaves and "bed holds" (bed holds are days when patients are in acute care facilities) by \$.11 per day. This is beyond the \$2.47 per day reduction made in September 1982.
- CA \*A 9/82 (-) California increased paid leave days for nursing home patients in certain programs for the mentally disordered from 18 to 30 days per year, separately defined "bed holds" as days when patients are in acute care facilities, and reduced reimbursement for all leaves and "bed holds" by \$2.47 per day.

- \* CO \*P /83 (+) (HB 1534) The Colorado legislature reports introduction of a bill to increase reimbursement to nursing homes to cover the costs of complying with state regulations.
- CO \*A 7/82 (+) Colorado began computing long term care facilities' maximum allowable rates semi-annually. This was legislatively mandated by House Bill 1288.
- CO \*A 7/82 (-) (HB 1288) The Colorado legislature enacted a law which became effective July 1982 and which authorized the agency to divide nursing home costs into two cost centers:
- (1) administration, property and board. For this cost center, the 90th percentile cap remains in place. However, an incentive allowance is offered. If costs are below the 90th percentile, the facilities share one-half of the difference between the actual and reasonable costs (the cap level), up to 12% of costs.
  - (2) health care and raw food costs. For this cost center, the 90th percentile cap was removed and the agency now pays 100% of reasonable costs.
- CT \*X 7/82 (-) Connecticut proposed regulations to alter the reimbursement system for nursing homes by capping rates at 150% of the statewide median rate. Anticipated savings were to be utilized to pay extra incentive allowances where nursing homes fall below the median statewide rate. This proposal has been dropped. (Contact: Ron Durie 203/566-4960.)
- \* DC \*A 6/83 (+) The District of Columbia eliminated its ceiling on the number of allowable nursing hours for patients in SNFs and ICFs.
- FL \*A 4/83 (-) The Florida legislature enacted a law which created a new reimbursement plan for long term care facilities based upon: 1) single level of payment; 2) geographic and size classifications and differentials; and 3) incentives for efficiency and quality of care. Payment ceilings will be reviewed and modified every six months.



*	GA	*A	4/83 (+)	Georgia increased the overall growth allowance for nursing homes from 12.6% to 17.5% and continued the rates based on the June 30, 1980 cost reports.
*	GA	*A	4/82 (+)	Georgia increased the overall growth allowance for nursing homes from 4.5% to 12.5% and continued the rates based on the June 30, 1980 cost reports.
	HI	*P	/83 (-)	Hawaii is considering the development of a prospective reimbursement system for nursing homes.
	ID	*A	1/82 (-)	<p>The State of Idaho implemented a new nursing home reimbursement system which has the following characteristics:</p> <ul style="list-style-type: none"> <li>● it classes facilities by type (i.e., hospital-based, freestanding SNF/ICF, freestanding ICF, or ICF/MR);</li> <li>● it places prospective caps on maximum payments by class of facility;</li> <li>● it pays providers who are below the cap an "efficiency incentive"; and</li> <li>● it recaptures depreciation paid providers if they sell the home for more than the historical cost plus depreciation paid.</li> </ul>
	ID	*A	/82 (-)	Idaho requested that all nursing homes voluntarily accept a 5 percent reduction in reimbursement.
*	IL	*A	7/83 (-)	Illinois did not update its nursing home rates for Fiscal Year 1984.
*	IL	*A	7/83 (-)	(HB 2058) The Illinois legislature enacted legislation to deny rate increases to nursing homes until July 1, 1984.
*	IL	*P	/83 (-)	Illinois is proposing not to update its nursing home rates for Fiscal Year 1985.
	IL	*A	7/82 (-)	Illinois placed a one-time-only, six-month hold on rate increases for nursing homes (SNFs, ICFs, and ICFs/MR).
	IL	*A	1/82 (-)	Illinois modified its nursing home reimbursement system in April 1982, retroactive to January 1982. It changed its method of patient needs assessment (used to determine



case mix for 21 services), eliminating the previous "point count" system, which had been performed by county offices every 90 days for SNFs, every 6 months for ICFs, or on demand or when a patient's needs changed. Patient needs levels are now assessed on a sample basis every six months, an average is taken, and one value is assigned for everyone in each facility.

- \*    IN    \*A    4/83 (-)    Indiana modified its nursing home reimbursement methodology by changing the way ownership costs (interest and depreciation) are reimbursed. Previously, the owner's actual costs were reimbursed. Now, the owner receives a capital return factor which covers the debt service, if reasonable, and a return on equity. (Thus payments are based not on the amount of the owner's debt, but on their equity.)
- IN    \*A    1/82 (-)    (SB 299) The Indiana legislature enacted a law which required the state's Department of Public Welfare to examine the need for changes in rate structure for institutional services, and to make recommendations concerning Medicaid hospital costs.
- \*    IA    \*A    7/83 (+)    The Iowa legislature set the ICF reimbursement rate at the 74th percentile of all facilities' per diems, as calculated from the June 30, 1981 cost reports.
- \*    IA    \*A    5/83 (-)    (HF 641) The Iowa legislature enacted a law which limited rate increases to 6 percent for nursing homes.
- IA    \*A    7/82 (-)    The Iowa legislature enacted SF 2304, which provides for no increase in the ICF per diem rates.
- IA    \*A    4/82 (-)    Iowa reduced SNF reimbursement to the maximum ICF or RCF (Residential Care Facility) payment rate for resident recipients when it is determined they do not require the SNF level of care. A residential care facility is a facility providing a lower level of care which is reimbursed with state funds only, since it is not eligible for Title XIX funds.
- IA    \*A    4/82 (-)    Iowa modified its payment rates for ICF beds reserved during patient leaves of absence. It will pay the maximum Medicaid per diem rate or 75 percent of audited allowable costs. The previous maximum was 80 percent of audited allowable costs.

IA	*A	4/82 (-)	Iowa reduced ICF reimbursement to the maximum RCF (Residential Care Facility) payment rate for resident recipients when it is determined they do not require the ICF level of care. A residential care facility is a facility providing a lower level of care which is reimbursed with state funds only, since it is not eligible for Title XIX funds.
*	KY	*A 1/83 (+)	Kentucky increased the maximum ICF reimbursement rate to \$34.29 per day, up from \$34.19.
*	KY	*A 12/82 (-)	Kentucky reduced the maximum reimbursement rate for free-standing SNFs to \$52.51.
*	KY	*A 12/82 (-)	Kentucky reduced the maximum reimbursement rate for hospital-based SNFs to \$81.02.
	KY	*A 12/82 (-)	Kentucky refined the inflation factor used in its prospective reimbursement methodology to one supplied by Data Resources, Inc., which is based more directly on nursing home inputs. The state previously used the CPI. This policy became effective with facilities' fiscal years ending after 12/31/82. Anticipated annual savings: \$2.5 million. (Contact: Ronnie Cohorn 502/564-7540.)
	KY	*A 7/82 (+)	Kentucky increased the maximum reimbursement rate for free-standing SNFs to \$52.69 per day, up from \$48.75 per day.
	KY	*A 7/82 (+)	Kentucky increased the maximum reimbursement rate for hospital-based SNFs to \$83.09 per day, up from \$75.65 per day.
	KY	*A 7/82 (+)	Kentucky increased the maximum ICF reimbursement rate to \$34.19 per day, up from \$32.55 per day.
LA	*P	1/83 (-)	Louisiana proposes to reduce by two percent reimbursement rates to SNFs and ICFs with the exception of ICFs for the handicapped.
LA	*A	7/82 (+)	Louisiana increased its reimbursement rates to nursing homes in accordance with its cost-related reimbursement plan and current cost report data. This rate increase became effective August 1982 for claims beginning July 1982.

ME	*A	7/82 (-)	Maine implemented a prospective reimbursement system for Intermediate Care Facilities. The new methodology diminishes internal limits on certain categories of expenses, allowing facility administrators more latitude; it allows facilities which limit their expenses to less than the Medicaid rates, while maintaining quality, to share in the resulting savings; and provides incentives for facilities to increase the number of Medicaid residents.
MD	*A	1/83 (+)	Maryland has implemented a new system for reimbursing nursing homes based upon an assessment of each individual patient's needs.
MD	*A	7/82 (+)	Maryland increased its rates for nursing homes, laboratories, physicians, pharmacists, dentists, medical supplies and equipment, ambulances and wheelchair vans, and medical day care.
*	MA	*A 4/83 (-)	Massachusetts reduced the cost adjustment factor and the rate of return on equity capital which is used in calculating interim payment rates for nursing homes.
*	MA	*A /83 (+)	(H 6774) The Massachusetts legislature enacted legislation revising reimbursement rates to rest homes so that rates reflect actual costs.
*	MA	*X 2/82 (-)	(H 4811) The Massachusetts legislature reported the introduction of a bill to deny reimbursement to any newly constructed nursing home. This proposal has been dropped.
	MA	*A 2/82 (+)	Massachusetts established an incentive in the form of bonus payments to promote placement of heavy care administrative day patients into nursing homes (additional cost: \$0.75 million).
	MA	*X /82 (-)	Massachusetts proposed to reimburse administrative days in acute hospitals at a flat rate of \$70 for a SNF-level patient and at a rate estimated to be \$64 for an ICF-level patient. This dual administrative day rate structure, if adopted, would supersede the previous payment of \$70 for all administrative day patients regardless of the level of care. This proposal has been dropped.
*	MI	*A 7/83 (-)	(HB 4558) Michigan's Appropriations Act contains a provision that sets the maximum profit factor for SNFs and ICFs at \$1.00 per day.



- MI \*A 1/82 (-) Michigan reduced the maximum profit factor for proprietary SNFs and ICFs from \$1.25 per patient day to \$1.00.
- MI \*A /82 (-) Michigan extended through October 1, 1982, its moratorium on increases in capital costs reimbursement upon sale or resale of nursing homes, which was originally scheduled to be lifted July 8, 1982, and once every five years thereafter. The moratorium was lifted October 1982.
- \* MN \*A 5/83 (-) (SF 695) The Minnesota legislature enacted a law which authorized the Commissioner of Welfare to establish method and set payment amount for ancillary services provided in nursing and boarding homes.
- \* MN \*A /83 (-) (H 742) Minnesota extended a limit of 8% on rate increases to providers, with the exception of nursing homes, until June 30, 1985.
- \* MN \*A 7/83 (-) Minnesota is modifying its nursing home program in several ways. It has moved to a prospective reimbursement system (see Reimbursement subsection), and is attempting to channel long term care patients into alternatives to institutionalization where appropriate. It has doubled its expenditures on alternative care and has implemented a number of demonstration projects. It has also established a moratorium on certification of additional nursing home beds (HF 670, SF 695), and has appointed an interagency board for quality assurance, to insure continued quality of care in nursing homes.
- \* MN \*P /83 (-) Minnesota is proposing to modify its nursing home reimbursement methodology. It would group nursing homes by the level of disability and establish one rate for all facilities within each level. Also, property-related reimbursement, based on the rent for use of space, would be insensitive to how providers manage their capital assets. At present, reimbursement rates are facility-specific and are indexed. The target date for full implementation is July 1985.



- \* MN \*A /83 (-) Minnesota has set a 6% limit on the increase in nursing home expenditures between 1983 and 1985. Administrative expenses and top management salaries will have specific increase limits.
- \* MO \*A 7/83 (-) (HB 825) The Missouri legislature enacted a law which provided that any increased costs resulting from a change of ownership or control of nursing homes shall not be recognized for reimbursement.
- \* MO \*A 7/83 (-) (HB 825) The Missouri legislature enacted a law which placed limits on reimbursement for capital expenses for newly-built nursing homes entering Medicaid after March 18, 1983 by establishing separate rates for building and equipment, movable equipment, land, and working capital.
- \* MO \*A 7/83 (+) (HB 825) The Missouri legislature enacted a law which increased nursing home rates by trend factors of: 1) \$.10 effective 7/1/83; 2) \$.10 effective 10/1/83; 3) \$.15 effective 1/1/84; and, 4) \$.15 effective 4/1/84.
- MO \*A 11/82 (-) Missouri adopted a state regulation to limit allowable cost overruns for new construction of nursing homes to 10% of initial project estimates.
- MO \*A 11/82 (-) Missouri adopted a state regulation to place an upper limit on reimbursement to non-exempted nursing home facilities to a maximum of 85% occupancy of licensed beds or certified beds if lesser.
- MO \*X 1/82 (-) (HB 1089) The Missouri legislature reported the introduction of a bill to revise its cost-related reimbursement systems for inpatient hospital and nursing home services. This bill did not pass.
- MO \*X 1/82 (-) (HB 1953) The Missouri legislature reported the introduction of a bill to limit nursing home reimbursement to the provider's per diem times a percentage of between 75% and 90% of licensed bed capacity and to limit reimbursement for new facilities to 110% of the original CON estimate. This bill did not pass.
- MT \*A /82 (-) Montana began tying nursing home reimbursement rates to grades of patient disability.

	NE	*A	8/82 (-)	Nebraska implemented a prospective reimbursement system for nursing home facilities. This is under litigation.
*	NE	*A	/82 (-)	Nebraska eliminated its allowance to proprietary nursing home owners of a profit factor set at 1-1/2 times the federal hospital insurance trust fund rate. However, an efficiency allowance is made which is the difference between the prospective cost allowance and the prospective maximum allowable rate, subject to a limit of \$1.00 per Medicaid patient day for non-proprietary and government facilities.
	NE	*P	/82 (-)	A state task force in Nebraska is considering a proposal to tie nursing home reimbursement rates to grades of patient disability.
*	NV	*C	/83 (-)	Nevada is considering modifying its method of reimbursing long term care facilities.
	NV	*A	1/82 (-)	Nevada will no longer guarantee an automatic annual increase, based on the CPI, in the prospective cost areas (administration and housekeeping) for long term care facilities. However, it will permit negotiations between the state and the long term care provider association for a rate increase, if the CPI rises.
	NV	*C	/82 (-)	Nevada is considering a pilot project involving capitation payments to LTC facilities for all physician services provided to LTC patients.
	NJ	*A	/83 (-)	New Jersey has changed its method of reimbursement to LTC facilities for buildings and land. The return on this property is now based on the Medicare rate of return.
*	NJ	*C	/83 (-)	New Jersey is considering establishing a separate peer grouping for county government-operated long term care facilities to develop per diem reimbursement rates based on a comparison of the costs associated with this separate peer group.
	NJ	*P	2/82 (-)	(S 511) The New Jersey legislature reports the introduction of a bill to permit hospitals to establish swing beds.

NY \*P 1/82 (-) (A 9388) The New York legislature reported that a bill had been introduced to deny reimbursement to residential health care facilities for costs associated with employee labor organizations.

\* NC \*A 7/83 (-) (SB 23) The North Carolina legislature enacted a law which limited reimbursement increases for indirect costs of SNFs and ICFs to 3.4 percent.

\* OH \*A 7/83 (-) (H 291) The Ohio legislature enacted a law which limited reimbursement to those SNFs and ICFs that have less than 10 or 10 percent Medicaid recipients the lesser of the statewide average rate or charges to non-Medicaid residents.

\* OH \*A 7/83 (-) (H 291) The Ohio legislature enacted a law which limited SNF and ICF reimbursement for administration and general service cost centers and established an efficiency incentive equal to fifty percent of the difference between actual costs and limits on property costs.

OH \*A 1/83 (-) The Ohio legislature enacted S.B. 530, which reduces interim payments to hospitals and nursing homes (except ICFs/MR) if expenditures are estimated to be greater than appropriations. Adjustments to recoup reductions will be made in FY 1984.

\* OH \*A /83 (-) (HB 100) The Ohio legislature enacted a law which requires the recalculation and placing of limits on administrative and general costs in nursing homes.

OK \*A 1/82 (+) Oklahoma raised per diem rates for SNF services.

OK \*A 1/82 (+) Oklahoma raised per diem rates for ICF services.

\* OR \*A 10/83 (-) Oregon dropped separate payment for high use oxygen for nursing home patients. Payment is now included in the per diem rate.



- \* OR \*A 7/83 (+) (HB 2480) The Oregon legislature enacted a law which directed the Senior Services Division to implement a nursing home reimbursement system based on patient needs to include: paying for direct care based on patient needs; separating patient care and dietary services from other amounts and prohibiting transfer of funds; paying for adequate staffing; and, paying for case management as performed by registered nurses.
- \* OR \*A /83 (-) (HB 2480) The Oregon legislature enacted a bill to reimburse nursing homes according to patient needs, by cost centers.
- \* PA \*P /83 (-) (H 627) The Pennsylvania legislature is considering a bill to establish prospective nursing home reimbursement with efficiency incentives for cost containment.
- PA \*A 9/82 (-) Pennsylvania has adopted regulations, as of September 1982, to stop paying nursing homes for depreciation and interest costs unless the institutions have received Certificate of Need (CON) prior to September 1982.
- \* PA \*A 7/82 (+) Pennsylvania raised reimbursement ceilings for ICFs and SNFs.
- PA \*A 7/82 ( ) Pennsylvania modified its reimbursement methodology for nursing homes by using the median rather than the average cost.
- RI \*A 1/82 (-) Rhode Island modified its nursing home reimbursement methodology, principally by dropping the Consumer Price Index (CPI) as the economic index used in computing inflation-related increases in reimbursement levels. In its place, it adopted HCFA's National Nursing Home Input Price Index, which is more reflective of nursing home costs. In addition, rate increases tied to economic trends will no longer apply to cost centers for interest and depreciation.
- \* SC \*A 4/83 ( ) South Carolina adopted a proposal to disallow certain non-patient care items in the calculation of nursing home reimbursement rates. However, the state was permanently enjoined from implementation by the federal courts on procedural grounds. The state is looking at ways to pursue the matter.



SC \*A 7/82 (-) South Carolina passed through a transitional phase, moving from the use of the Consumer Price Index to a local index (designed by the South Carolina Division of Research and Statistical Services, Budget Control Board) in determination of the inflation factor used in computing nursing home reimbursement rates. The transition was completed in July 1, 1982.

\* SD \*X /83 (+) (SB 203) The South Dakota legislature considered a bill to establish guidelines for nursing home reimbursement as follows: 1) Rates would be based on the greater of 90 percent of capacity or average daily occupancy; 2) Rates would be increased by an inflation factor equal to the increase in the nursing home component of the national health care index; 3) It would include a 5 percent profit factor not to exceed \$2 per patient day for FY84; and, 4) Full depreciation would be calculated separately and would not be subject to a cap. It did not pass.

SD \*A 7/82 (-) South Dakota reduced payment to 50 percent of the actual rate to nursing homes for reserved beds during patients' hospitalizations.

SD \*X 1/82 ( ) (SB 218) The South Dakota legislature reported that a bill was introduced to limit private pay nursing home rates to 110% of Medicaid rates for homes participating in Medicaid. This proposal was dropped.

VT \*A 3/83 (-) Vermont implemented a prospective nursing home reimbursement system in March 1983, with rates related to reasonable cost.

VA \*A 4/83 (-) Effective April 1, 1983, Virginia limited all nursing home reimbursement to the appropriate regional ceiling in the following manner:

1. Two regional ceilings were established for free-standing Intermediate Care Facilities (ICFs): One for Northern Virginia and the other for the rest of the state. A separate ceiling was established for hospital-based ICFs. One ceiling was established for all Skilled Nursing Facilities (SNFs) in Northern Virginia, and one for all other SNFs in the state.

2. The calculation of the initial regional ceilings, as of July 1, 1982, was based on available allowable cost data for all nursing homes in the calendar year 1981. Individual nursing home operating costs were advanced by a reimbursement escalator from the nursing home's year end to July 1, 1982. The median was determined using this data. These ceilings will be adjusted once each quarter by the escalator. Thus, the quarterly ceilings will be used for nursing homes which have a fiscal year beginning within the quarter.
3. Subsequent to June 30, 1982, the regional ceilings will not be recalculated on actual costs, but will be updated by the escalator.

The reimbursement escalator is a twelve-month average of the Bureau of Labor Statistics Consumer Price Index (CPI), adjusted quarterly. This Index has excluded from it housing and interest cost components.

Plant costs continue to be reimbursed in accordance with the existing formula.

The prospective rate for each nursing home is based on the home's allowable costs plus the escalator, or the appropriate ceiling, or charges, whichever is lower. The disallowance of unallowable costs will be reflected in the subsequent year prospective rate determination.

For those nursing homes whose operating costs are below the ceiling, an incentive plan was established whereby a nursing home were be paid, on a sliding scale, up to 25% of the difference between its allowable operating costs and the per diem ceiling for its assigned group.

VA \*A 7/82 (-)

Virginia revised its Nursing Home Reimbursement formula in accordance with the following policies: A nursing home whose fiscal year ends prior to April 1, 1983, can choose to have a new rate determined under this new reimbursement system instead of maintaining a rate determined by the nine-month floor. In the event that the revised prospective rate calculation is less than that rate to which the provider is entitled as of June 30, 1982, as determined in accordance with the existing

Virginia Nursing Home Payment System and applicable HIM-15 regulations, the rate on June 20, 1982, will remain in effect until March 31, 1983.

VA \*A /82 (-) Virginia eliminated completely its add-on for nursing home reimbursement.

VA \*A /82 (-) Virginia established a policy requiring that, in the event of a sale of a nursing home, the purchaser must have a valid Certificate of Public Need in order to receive program reimbursement.

VA \*A /82 (-) Virginia integrated the following concepts into its reimbursement principles for the sale of nursing homes:

1. The cost of a nursing home when the sale involves related parties will be limited to the historical cost of the seller.
2. The allowable cost for a sale of a facility shall be the lesser of the purchase price or fair market value determined by independent appraisal. (Purchase price is the amount agreed to by the buyer and seller.)
3. The useful life of the purchased facility will be determined by averaging the appraised life expectancy and forty (40) years.
4. All movable equipment purchased in the facility will have a useful life of fifteen (15) years.
5. The buyer's basis for cost recovery will be reduced by the value of the depreciation recapture due the state by the seller, until arrangements for repayment have been agreed upon by the program.
6. In the event the facility is owned by the present owner for less than five (5) years, the cost basis of the purchased facility to the buyer will be the historical cost of the seller.
7. The interest cost increases resulting from the sale will be subject to the ceilings in effect after July 1, 1982 for construction of facilities.



8. The lease cost of a nursing home will not exceed the equivalent of the total annualized cost of depreciation, interest, insurance, taxes, equity and legal fees to the lessor as would be allowable under the sale of a facility.

- \* WA \*A 7/83 (-) The state of Washington adopted a reduced reimbursement level (at the statewide average SNF rate) for administratively necessary hospital days; that is, days of hospitalization for which medical necessity is below that appropriate for acute hospital care.
- \* WA \*A 7/83 (-) The state of Washington is implementing a prospective system of rate-setting for SNFs and ICFs, using retrospective settlements of the lesser of rate or cost.
- \* WA \*A 7/83 (-) The state of Washington placed a ceiling on SNF and ICF patient care cost centers, based upon the average disability score for the facility.
- \* WA \*A 7/83 (+) The state of Washington's legislature appropriated \$3.3 million for a two-year period to enhance rates for low-paid nursing homes where there are historically low staffing patterns and findings of deficiencies.
- WA \*A 1/82 (-) The Washington legislature enacted a law which provides for reimbursement of nursing homes on the basis of cost centers: patient care, food, administration and operation, and property, plus a return on equity.
- \* WI \*P /84 (-) Wisconsin plans to limit nursing home rate increases to 3 percent per year, across the board, starting in 1984.
- WI \*P /83 (-) Wisconsin is considering a proposal to limit capital costs in reimbursement of nursing homes.



## 32. ICF/MR Services

### A. Amount, Duration and Scope

- \* AL \*A 7/82 (-) The Alabama state plan was amended so that the state may establish community mental retardation units (ICFs/MR) providing 24-hour personal care, habilitation, development, and supportive health service to at least four but no more than 15 mentally retarded persons or persons with related conditions.
- CA \*A 9/82 (+) The State of California has established a category for small ICF/DD habilitative facilities of 15 beds or less. Emphasis is on habilitative rather than medical/nursing home model to provide a more homelike environment.
- CT \*X /82 (-) The State of Connecticut considered limiting the number of ICF/MRs which it would reimburse to the number of facilities currently receiving reimbursement. This proposal was dropped.
- \* FL \*A 4/83 (-) Florida decreased coverage of ICF/MR bed reservations during therapeutic home visits from an unlimited number of days to 30 days per fiscal year, with the provision for a one-time exception.
- \* NM \*A 3/83 (+) New Mexico added coverage of swing bed services, allowing small rural hospitals to use inpatient facilities to furnish ICF and SNF services.
- \* OH \*P 11/83 (+) Ohio is proposing to expand coverage of ICF/MR leave days, for either hospitalization or therapeutic purposes, to 30 per year, with additional therapeutic days allowed with prior authorization.
- \* OH \*A 7/83 (+) (H 291) The Ohio legislature enacted a law which allowed an unlimited number of reserved bed days for ICFs/MR, provided that prior authorization is obtained.

### B. Utilization Controls

- \* AL \*A 10/82 (-) The administration of prior authorization for coverage of ICF/MR services was shifted from the PSRO to the Alabama Medicaid Agency or the Department of Mental Health, as applicable.

- \* NE \*A 4/83 (-) Nebraska changed its recertification requirements for all ICF/MR clients from every 60 days to once a year.
- SC \*A 9/82 ( ) In South Carolina pre-certification for mental retardation care in intermediate care facilities for the mentally retarded (ICFs/MR) is now carried out by the four regions of the Department of Mental Retardation as the designee of DSS, effective 9/82.
- VA \*A /82 (-) Virginia began requiring physician certification and review of the appropriateness of habilitative services provided to a recipient in an ICF/MR every 90 days.

### C. Reimbursement

- \* AK \*A 7/83 (-) (SB 85) The Alaska legislature enacted a law which established the Medicaid Rate Commission to set prospective payment rates for all health facilities, including: hospitals, SNFs, ICFs, ICFs/MR, rehabilitation facilities, inpatient psychiatric facilities, home health agencies, rural health agencies, and outpatient surgical clinics.
- IL \*A 7/82 (-) Illinois placed a one-time only six-month hold on rate increases for nursing homes (SNFs, ICFs, and ICFs/MR).
- KY \*A 1/82 (+) Kentucky removed the maximum daily reimbursement rate for ICFs/MR.
- \* ME \*A 7/83 (+) Maine raised the reimbursement ceiling for developmental training for ICF/MR residents from \$4,575 to \$6,000 per year per client. In addition, verification is now required of the costs of developmental training services when the services are provided under contract with an unrelated organization (it was already required for services provided by related organizations).

- ME \*A 7/82 (-) Maine implemented a prospective reimbursement system for ICFs/MR. The new methodology diminishes internal limits on certain categories of expenses, allowing facility administrators more latitude; it allows facilities which limit their expenses to less than the Medicaid rate, while maintaining quality, to share in the resulting savings; and provides incentives for facilities to increase the number of Medicaid residents.
- \* NE \*P /83 (-) Nebraska proposes to add a separate care classification, for long term care reimbursement purposes, for state-owned ICFs/MR. State-owned ICFs/MR are very expensive and have raised the rates, based on the range of costs within the classification, for the entire classification of ICFs/MR.
- \* OH \*A 7/83 (-) (H 291) The Ohio legislature enacted a law which established separate reimbursement rates for ICFs/MR with eight or fewer beds. The rate is based on the statewide average ICF/MR rate with special considerations to those facilities that require staff to be awake and on duty 24 hours per day.

### 33. Inpatient Psychiatric Services for Individuals under 22

#### A. Amount, Duration and Scope

- \* AL \*A 10/82 (-) Alabama eliminated coverage of inpatient psychiatric services for individuals under 22 in psychiatric hospitals.
- \* FL \*A 3/83 (-) Florida discontinued the Inpatient Psychiatric Services for Individuals Under Age 21 Program.
- \* KS \*A 9/83 (-) Kansas reduced the limitation on psychiatric hospital stays from 21 to 14 days: Any stay beyond 14 days must be prior authorized. Prior authorization will be limited to: (1) those situations where it is documented that the recipient is in the custody of the state or such custody is being sought and placement has not been made or transfer completed. Additionally, the physician and social worker must agree that the child cannot be discharged; and (2) other situations which are supported by medical judgment that discharge by the 14th day is not possible.

#### B. Utilization Controls

#### C. Reimbursement

- \* AK \*A 7/83 (-) (SB 85) The Alaska legislature enacted a law which established the Medicaid Rate Commission to set prospective payment rates for all health facilities, including: hospitals, SNFs, ICFs, ICFs/MR, rehabilitation facilities, inpatient psychiatric facilities, home health agencies, rural health agencies, and outpatient surgical clinics.



34. Institutions for Mental Disease for Individuals 65 and Over

A. Amount, Duration and Scope

- DE \*A 8/82 (+) Delaware added ICF services for individuals over age 65 in IMDs.
- \* FL \*A 3/83 (+) Florida implemented a change in its inpatient hospital services for individuals age 65 or older in institutions for tuberculosis or mental diseases: the state increased coverage of bed reservations during therapeutic home visits from 18 days during any 12-month period to 30 days per fiscal year.

B. Utilization Controls

C. Reimbursement

35. TB Institutions for Individuals 65 and Over

A. Amount, Duration and Scope

- \* AL \*A 4/83 (-) Alabama reduced from 15 to 12 days per calendar year the total number of inpatient hospital days for those 65 and over in a TB institution.
- \* FL \*A 3/83 (+) Florida implemented a change in its inpatient hospital services for individuals age 65 or older in institutions for tuberculosis or mental diseases: the state increased coverage of bed reservations during therapeutic home visits from 18 days during any 12-month period to 30 days per fiscal year.

B. Utilization Controls

C. Reimbursement

### 36. Christian Science Sanitoria

#### A. Amount, Duration and Scope

TN    \*A    7/82 (+)    In July 1981 Tennessee had eliminated coverage of the following services for most medically needy recipients: inpatient and outpatient hospital services, physician and pharmacy services, prosthetic devices, and Christian Science sanitoria services. Among the medically needy groups still able to receive physician and pharmacy services were nursing home residents. A federal court later ruled that this discriminated by class (according to living arrangements), and required the state to retroactively pay for services denied to medically needy recipients during this period. Tennessee therefore in July 1982 increased coverage for the medically needy; they will now receive the same services as the categorically needy. At the same time, Tennessee reduced its medically needy eligibility population to only pregnant mothers and children under 21 in special groupings.

#### B. Utilization Controls

#### C. Reimbursement

### 37. Home Health Services

#### A. Amount, Duration and Scope

- CA \*A 9/82 (-) The California legislature expanded the Medi-Cal scope of benefits to include "in-home medical services" for beneficiaries who would otherwise require higher cost, acute hospital care. Such services may be provided in the patient's home, or through a skilled nursing facility, intermediate care facility, or a shared or congregate living arrangement if the patient's home is unavailable or inappropriate. The law adds to covered benefits those utility bills directly attributable to the operation of 24-hour life-sustaining medical equipment.
- \* MO \*A 1/83 (+) Missouri added coverage of home apnea monitors.
- MO \*A 7/82 (-) Home health coverage was added for Missouri recipients under age 21 if recipient otherwise would require acute hospital care.
- \* NE \*A 1/83 (-) Nebraska revised its home health agency coverage:
- It defined the purpose of such coverage;
  - It added a requirement for a plan of care and treatment record signed by a physician and reviewed every 60 days by the physician and agency personnel which is available for review;
  - It added specific guidelines for coverage of home health agency services;
  - It added the requirement that claims for Medicare-eligibles must include documentation that the services billed are not covered by Medicare, and specified that Medicaid may cover services denied by Medicare if denied for reasons other than a lack of medical necessity and if within Medicaid's scope;
  - It added the requirement that all claims be made on HCFA 1500 forms;

- It added limitations and requirements for home health agency services, including prior authorization, multiple services, student nurses, teaching and training, medical supplies, second visit on the same day, and enterostomal therapy.

- \* NH \*A 7/83 (+) New Hampshire raised its limits on home health services from 30 to 60 visits per recipient per year.
- NJ \*A 7/82 (-) New Jersey limited home health care to two levels of care, acute and chronic.

#### **B. Utilization Controls**

- MO \*A 5/82 (-) Missouri began conducting pre-payment reviews of all home health claims to determine if the services are medically necessary and are required in the patient's plan of care as signed by a physician.
- \* NE \*A 1/83 (-) Nebraska began requiring prior authorization for all home health agency services, both initially and every 60 days thereafter. The eligibility of both client and provider must be verified, and there must be documentation of the physician's order and the home health agency's treatment plan.
- \* WI \*P /83 (-) Wisconsin is proposing to require, for home health services, prior authorization for services above a specified limit. The criterion for approval would be medical necessity.

#### **C. Reimbursement**

- \* AK \*A 7/83 (-) (SB 85) The Alaska legislature enacted a law which established the Medicaid Rate Commission to set prospective payment rates for all health facilities, including: hospitals, SNFs, ICFs, ICFs/MR, rehabilitation facilities, inpatient psychiatric facilities, home health agencies, rural health agencies, and outpatient surgical clinics.
- CT \*C 10/82 (-) Connecticut's single state agency is considering the assumption of the rate-setting role for home health agencies. This role presently belongs to the Commission on Hospitals and Health Care. This would require the passage of amending legislation.



*	IN	*C	/83 (-)	Indiana is considering modification of its reimbursement methodology for home health agencies. It is attempting to design an approach which would include an incentive for efficiency by providers. The current system reimburses reported costs.
	MI	*A	8/83 (-)	The State of Michigan began reimbursing home health services on a fee-for-service basis, the lesser of charge or screen. The previous policy was the payment of a percentage of charges.
*	MO	*C	/83 (-)	Missouri is considering the establishment of a fee schedule for home health services.
	MO	*P	2/82 (-)	Missouri has proposed to recover over-payments through home health cost settlements.
	NV	*A	4/82 (-)	Nevada changed its payment methodology for home health agency services from a Medicare-type cost reimbursement to a fixed fee schedule for each service.
	NH	*C	/82 (-)	The State of New Hampshire is considering changing its reimbursement for home health services to a flat fee-for-service rate. Currently, Medicaid pays the rates charged to the public.
	PA	*A	9/82 (+)	Pennsylvania increased its fees from \$13 to \$18 for home health agency services, in an effort to encourage home health care as an alternative to institutional long term care.
	UT	*A	/82 (-)	Utah began reimbursing home health agencies for visits at specific encounter rates, based on the averaging of costs. The previous payment rate was the lower of cost, the area prevailing rate, or billed charge.
	WI	*A	7/82 (-)	Wisconsin implemented a maximum allowable rate by geographic/demographic area (i.e., rural/urban) for home health services.

### 38. Personal Care Services

#### A. Amount, Duration and Scope

- \* ID \*A 7/83 (+) The Idaho state legislature enacted a bill permitting the state Medicaid agency to cover personal care services in April 1981. This was implemented in July 1983.
- \* MN \*A 6/83 (+) (SF 1234) The Minnesota legislature enacted a law which added personal care attendant services. Services cannot be provided by a relative; provider must be qualified; services must be prescribed by a physician in accordance with a plan of care, and services must be supervised by a registered nurse.
- MO \*A 7/82 (-) The Missouri legislature enacted a law adding coverage of personal care services for those recipients meeting program guidelines. The goal is to effect a cost-savings in the nursing home program.
- \* NY \*A 4/83 (-) To control the growth of the personal care services program, New York prohibited the provision of continuous 24-hour services except under specified circumstances.
- \* NY \*P /83 (-) New York has proposed to implement a needs determination procedure in order to allocate hours of personal care services for each local social services district based upon demographic information.

#### B. Utilization Controls

- NE \*X /82 (-) Nebraska considered requiring prior authorization of day care and partial hospitalization services. However, this proposal was dropped.
- \* NY \*P /83 (-) New York is proposing to establish standards for the authorization of personal care services which will define the linkage between the authorization of specific amounts of service and the need for specific functions, such as nutrition and environmental support or routine personal care tasks (e.g., bathing, dressing and grooming).

### C. Reimbursement

- \* MD \*A 5/83 (+) Maryland increased its fees for personal care services.
- OK \*A 1/82 (+) Oklahoma raised per diem rates for personal care services.

### 39. Other Community-Based LTC Services

#### A. Amount, Duration and Scope

- CT \*P /83 (+) (H 5424, H 5614, H5745): The Connecticut legislature has reported the introduction of bills that would provide adult day care services to Medicaid recipients. In previous years, similar bills have been introduced but have not been enacted.
- \* CT \*A /83 (+) (HB 8022) The Connecticut legislature enacted legislation to expand, and make permanent, its respite care program.
- \* ID \*A /83 (+) Idaho received approval for a state plan amendment to cover home care for certain disabled children who would otherwise be ineligible because of deemed income.
- IN \*X 1/82 (+) (SB 359) The Indiana legislature reported that a bill had been introduced to provide Medicaid reimbursement to the developmentally disabled for day developmental services in ICFs and ICFs/MR. These services include training in communication and social functioning, assistance in daily living activities, and provision of remunerative employment. This bill did not pass.
- \* KY \*C /83 (+) Kentucky is considering adding coverage of certain hospice services.
- \* LA \*P /83 (-) Louisiana proposes to suspend home and adult day care programs.
- LA \*A 5/82 (+) Louisiana began providing coverage of homemaker services on a time-limited, crisis basis when needed to maintain the recipient in the home.
- \* MO \*A 7/83 (-) Missouri added Adult Day Health Care as a covered service for recipients meeting program guidelines. This is to effect a cost savings in the nursing home program. The Missouri legislature enacted a bill (HB 170) mandating

this coverage in July 1982 but no funding was made available for implementation until July 1983.

- \* NY \*A 1/84 (-) State legislation has been passed to permit New York State hospices to participate in the Medicare Program and to permit Medicaid participation subject to federal approval.
- \* WA \*A 10/82 (-) The state of Washington began covering private duty nursing services for the categorically needy. Prior authorization is required. This will provide a less costly alternative to institutionalization for certain recipients.

#### **B. Utilization Controls**

- \* MN \*A /83 (-) (SF 695) The Minnesota legislature enacted a law which includes boarding home placements within the pre-admission screening program. In addition, pre-admission screening will be required for nursing home applicants who will become eligible for Medicaid within 180 days of admission. The previous limit was 90 days.
- \* SD \*A 7/83 (-) South Dakota imposed recipient cost-sharing for mental health center services of five percent of the allowable reimbursement for each procedure billed.
- \* WA \*A 10/82 (-) The state of Washington began covering private duty nursing services for the categorically needy. Prior authorization is required. This will provide a less costly alternative to institutionalization for certain recipients.

#### **C. Reimbursement**



## II. ADMINISTRATION AND MANAGEMENT

### A. Reducing Eligibility Errors

- \* AL \*A 8/83 (-) Alabama developed an automated Medicaid Application system to reduce the applicant eligibility error rate caused through Medicaid District Office worker miscalculations.
- \* AZ \*A /83 (-) (SB 1279) The Arizona legislature enacted a law which makes incentive payments to counties for low eligibility determination error rates.
- \* AZ \*A /83 ( ) (SB 1279) The Arizona legislature enacted a law which establishes financial responsibility criteria for counties and the state in eligibility determination.
- CA \*A 7/83 (-) California law now provides for the imposition of a Medi-Cal eligibility quality control program at the county level, and authorizes the Department to assess financial sanctions for excessive error rates. It also provides for a "pass-through" of federal sanctions for exceeding federal error rates, and provides for county financial responsibility for increased program costs due to improper application of Department of Health Services regulations or instructions. Savings are indeterminate.
- CA \*A 9/82 (-) California now requires that the information provided on the Medi-Cal application form be verified for accuracy before determining eligibility. Once eligibility is verified, it will be effective beginning with the month of application. A special provision is made in the event that documentation is unavailable.
- CA \*A 1/82 (-) California implemented a demonstration project Earnings Clearance System in which Medicaid Eligibility Records were matched with other state files containing earnings information.
- \* CO \*A 7/83 (-) (SB 137) The Colorado legislature enacted a law which established procedures to allow computer match of Medicaid applicants with records of financial institutions and insurance companies.
- KS \*A 7/83 (+) Kansas allocated funds for the hiring of one staffperson to train eligibility determination workers.

MD \*P 10/82 (-) Maryland is developing an eligibility verification system. ID cards for Medicaid eligibles list an expiration date, usually three months from the date of issue. Heretofore, Maryland has reimbursed for services provided between the time of a cancellation in coverage and the expiration date on the ID card. However, with the implementation of a new automated on-line system for providers' use in verifying eligibility, providers will be placed at risk and will not be reimbursed for services provided to ineligible patients. The system can be accessed 24 hours a day by the use of a touch-tone telephone.

\* MA \*A 12/83 (-) Massachusetts developed a supervisory review instrument for Medicaid to ensure accuracy of applications/redeterminations. This was backed by a Central Office (of the Massachusetts Department of Welfare) monitoring effort.

MA \*A 9/83 ( ) Massachusetts began requiring monthly (or periodic) reporting for all Medicaid AFDC cases.

MA \*A /83 (-) Massachusetts is redefining its redetermination priorities for the medically needy population.

\* MA \*C /83 (-) Massachusetts is considering an automated tickler system to monitor bank accounts close to the resource maximum.

MA \*A 10/82 (-) Massachusetts introduced monthly reporting for all AFDC cases with present and/or past earned and/or unearned income.

MA \*A 9/82 (-) Massachusetts improved identification of recipient assets through the use of tape matches with bank service bureaus.

MA \*A 9/82 (-) An agreement was formalized between Massachusetts Medicaid and the Social Security Administration for an exchange of information regarding SSI recipients who receive automatic Medicaid coverage.

MA \*A 6/82 (-) Massachusetts Medicaid forms have been revised for submission of medical and social data to the State Medicaid Review Team in an attempt to reduce the number of deferred decisions.

	MA	*A	4/82 (-)	Massachusetts revised and expanded application and redetermination forms in an attempt to capture all information necessary to comply with policy changes and verification requirements promulgated with issuance of the new Medicaid Policy Manual in December 1981.
*	MA	*A	4/82 (-)	Massachusetts instituted the monitoring of all individuals' incomes during the application and redetermination processes through computer matching with other state agencies.
	MA	*A	2/82 (-)	Massachusetts centralized eligibility determination and redetermination for long term care cases. Contact: Marcia Kadnoff 617/727-7151.
	MA	*X	1/82 ( )	(H 192) The Massachusetts legislature reported that a bill had been introduced requiring that the Medicaid eligibility of residents in state schools for the mentally retarded be redetermined at least once every twelve months. This proposal was dropped.
	MA	*P	1/82 (-)	(S 676) The Massachusetts legislature reported that a bill has been introduced to implement a complete identification system of recipients.
*	MI	*A	7/83 (-)	(HB 4558) Michigan's Appropriations Act authorizes the Department of Social Services to require assistance applicants to furnish a copy of their most recent federal income tax return.
*	MN	*A	6/83 (-)	(SF 1234) The Minnesota legislature enacted a law which required that responsible county pay the state one-half of federal disallowances based on quality control rates for AFDC, Medicaid, or food stamps.
	MS	*P	1/82 (-)	(HB 506) The Mississippi legislature reported the introduction of a bill to require that the Department of Public Welfare, Board of Health, and Medicaid Commission coordinate and monitor application procedures for public assistance programs.
	NE	*A	7/82 (-)	Nebraska began requiring ADC-related Medicaid recipients, with the exceptions of those receiving foster care and refugees, to report their income on a monthly basis.



NJ \*A 12/82 (-) In New Jersey, automated Medicaid eligibility systems were installed in County Welfare Agencies and local Medicaid offices to provide instant eligibility data verification, with full statewide installation by the end of 1982.

NC \*A 6/82 (-) In North Carolina redesign of the eligibility sub-system is planned with a phased in approach. Phase I was completed in the Spring of 1981 and involved installation of a computer terminal network in the 18 counties having the highest assistance caseloads. Using an on-site data entry terminal hook-up to the state's computer system, these counties are responsible for batching, entering, editing, and controlling all data for AFDC, Medicaid, and state supplementation cases.

A third-party liability sub-system was put in place as of October 1981 and feeds into Phase II of redesign implemented in June 1982. Phase II involved extensive reprogramming to handle additional data collection, storage and reporting, and expanded on-site data entry to the remaining 82 counties. Phase III of the redesign effort will involve extensive modification of forms and implementation of eligibility determination capability.

OR \*P 6/82 (-) Oregon is developing an integrated eligibility system.

RI \*A 10/82 (-) Rhode Island expanded its utilization of bank clearances in the eligibility and recertification processes.

\* TX \*A 4/82 (-) Texas began requiring that a newborn be certified eligible for Medicaid before newborn care (other than delivery charges) is paid for by the agency. (The claim must be made using the newborn's Medicaid number.) (It was found that, previously, a significant number of the newborns whose care was covered were later determined to be ineligible for Medicaid.)

WA \*X /82 (-) Washington proposed to implement error-prone profiling. This proposal was dropped.

WI \*A 10/82 (-) Wisconsin began requiring monthly reporting of income by recipients.

WI \*A /82 (-) Wisconsin began monitoring eligibility determination workers' performance.



WI \*A /82 (-) Wisconsin began monitoring client income through linkages with other employment data files.

**B. Maximizing Payments From Other Sources**

- \* AK \*A 10/82 (-) Alaska has entered into a buy-in agreement with Medicare for payment of Part B premiums for dual entitlements.
- CA \*A 1/83 (+) California law now requires cooperative, mutually agreeable contracts between Medi-Cal and all private third-party payors (including health care plans) to identify, at the department's request, any Medi-Cal beneficiaries who have entitlement to other health care coverage.
- CA \*A 7/82 (-) California statutes now provide that counties may contract with the Department of Health Services for the detection and collection of debts due from Medi-Cal beneficiaries who have been retroactively determined to be wholly or partially ineligible for services received. An incentive of 10% of net General Fund collections after costs is provided to the counties.
- CA \*A 7/82 (-) California statutes now require the Department of Health Services to maximize identification of private health care coverage through collection of detailed information on coverage at the time of eligibility determination and redetermination. Counties will be reimbursed for costs associated with gathering the data. The Department of Health Services will computerize the data, gather patient histories and bill insurance companies for services.
- CA \*A 3/82 (-) Recent changes in California law now require the Department of Health Services to contract with third party liability contractors to recoup payment for health services for Medi-Cal beneficiaries.
- CA \*A 1/82 (-) The California Workers' Compensation Appeals Board is now required to exchange information with the Department of Health Services to assure that Medi-Cal services that are reimbursable through Workers' Compensation are identified.

- CA \*A 1/82 (-) California state law now provides for recovery of health care costs from the estates of over-age-65 Medi-Cal beneficiaries in certain instances.
- CO \*P /83 (-) Colorado is considering a proposal to phase in an automated program for identification of Medicare buy-in recipients and for retroactive recovery of claims payments for these recipients. (The state is presently operating a manual program.) The first phase would be automation of Part B. Part A would continue to be operated manually until it is phased in in 1984.
- CO \*A 7/82 (-) Colorado installed a third-party liability subsystem which will increase third party liability recoveries and also prevent payment of claims in cases where it is known that the recipient has another source of coverage. The state expects to save approximately \$671,000 during its 1983 fiscal year as a result of this effort.
- CO \*A 4/82 (-) Colorado initiated an intensive program involving the state's Veterans Affairs Division and the Division of Medical Assistance in order to identify dually-entitled nursing home recipients eligible for additional VA benefits. This has resulted in a substantial savings to the state. Additional savings will be realized because many recipients are due a retroactive benefit and will thus become ineligible for Medicaid for at least one month.
- CO \*A 1/82 (-) Colorado implemented manual operation of a program for identification of claims for "Medicare buy-in" recipients and for retroactive recovery of claims payments for these recipients. The state has been saving approximately \$500,000 per fiscal year through this initiative.
- \* CT \*A 10/83 (-) (SSB 851) The Connecticut legislature enacted a law that requires any medical insurance or similar benefits due to a Medicaid recipient resulting from a claim against a third party payer be assigned to the Department of Income Maintenance (DIM). Payors are required to reimburse DIM directly.
- CT \*P 2/82 (-) (H 5222) The Connecticut legislature reports the introduction of a bill to reduce fraud by auditing property tax records.

CT \*A 1/82 (-) The Connecticut Medicaid program has entered into a contract with the state's Legal Assistance to the Medicare Program (a part of its legal services program) whose purpose is to advise dually-entitled nursing home patients of their right to appeal Medicare denials and terminations, and to assist in such acts.

CT \*P /82 (-) The State of Connecticut is developing a proposal for implementation of a third-party liability program, which was mandated by state legislation. A contract is being negotiated for updating MMIS by phasing in a TPL subsystem based on a HCFA general system design.

Health insurance companies will be required to furnish the state agency with insurance information about Medicaid recipients and applicants. Legislation mandated the automatic assignment of rights, and private insurers will be billed directly. Also, information will be shared by another state agency in regard to those absent parents required to provide child support.

FL \*X 7/82 (-) Florida proposed that nursing homes participating in Medicaid must be certified for Medicare as well, thus allowing the state to capture the Medicare payments currently being by-passed due to certain facilities being Title XIX-certified only. This proposal was later dropped.

FL \*A 7/82 (-) (SB 583) The Florida legislature enacted a bill to strengthen third party liability efforts.

GA \*A 2/82 (-) The Georgia legislature reported that a bill had been introduced to require children to contribute to the cost incurred by their parents in nursing homes. This bill applies to children having an income of at least \$40,000 per year. The maximum amount of the contribution is \$4.00 per day (HB 1204). The Georgia legislature subsequently passed a bill which requests the Medicaid agency to prepare a plan for family supplementation to be implemented if the federal government lifts its restrictions or grants a waiver.

HI \*A /83 (-) (SB 2180-82) The Hawaii legislature reported passage of a law to assign rights of recovery from third parties.



- HI \*P /83 (-) (HB 99) The Hawaii legislature reports introduction of a bill to establish a third party liability recovery unit within the state Medicaid agency.
- \* ID \*A 10/83 (-) (HB 28) The Idaho legislature passed a law to require the families of Medicaid nursing recipients to contribute to the cost of their care. Individuals responsible to contribute include adult children and parents of children over age 21. Contributions are based on income and the federal poverty guidelines. The program is administered as third party liability to prevent any recipient from losing Medicaid eligibility.
- ID \*A 2/83 (-) Idaho began enforcing a state law which requires parental responsibility for medical care for individuals under 21. The state will pay claims for the children's care, but will recoup funds from the responsible parents.
- ID \*A 3/82 (-) The Idaho legislature enacted a law requiring subrogation of funds. In cases where funds are paid to a Medicaid recipient by a third party, the Medicaid program can claim a part of these funds, the amount depending upon Medicaid expenditures for the recipient. This measure was previously a part of the state's Medicaid regulations, but enactment into law strengthened the ability to enforce it.
- IN \*A 7/82 (-) Indiana expanded its liability recovery program.
- IN \*A 1/82 (-) The Indiana General Assembly enacted legislation requiring the state agencies to put all potential third parties on notice. The status of the state's claim was upgraded from a subrogation interest to a lien. Insurers are required to provide information on Medicaid recipients and to accept the state's claim in lieu of provider-signed claims. Insurers who make direct payment to recipients after receiving notice have not discharged their obligation to make payment to Medicaid. Application for Medical Assistance or receipt of medical benefits is deemed to be a release of information for third party recovery activities.



IN \*X 1/82 (-) (SB 400) The Indiana legislature reported that a bill had been introduced which would require contribution toward the cost of institutional Medicaid services by children or parents of institutionalized recipients. (This would apply only to those relatives between the ages of 21 and 65). The Department of Public Welfare will develop a payment scale based on income. The maximum contribution is to be \$100/month. Failure to contribute would constitute a Class D felony. This proposal was dropped.

\* IA \*P /83 (-) (SF 498, HF 440) The Iowa legislature reports introduction of bills to increase TPL recovery efforts.

KS \*A 7/82 (-) Kansas implemented a third party liability system as part of its MMIS. Claims are denied on a prepayment basis and the provider is given information available in the system to assist in billing the third party.

KS \*P /82 (-) Kansas is considering a proposal to recover Medicaid funds from absent parents.

MD \*A 7/82 (-) Maryland began allowing the Medicaid agency to subrogate personal injury protection insurance. This was mandated by passage of HB285 by the state legislature.

MD \*A 7/82 (-) Maryland began allowing the courts to mandate medical support in successful paternity suits. This was made possible by passage of HB447 by the state legislature.

MD \*A 7/82 (-) (SB 117) The Maryland legislature adopted a law to expand third party liability efforts. The bill required insurance carriers to reimburse the state for claims filed within two years of treatment which are based on information sufficient to determine insurer's liability.

MA \*P /83 (-) Massachusetts is developing a proposal to implement a program enhancement in which Medicare denials for SNF benefits for Medicaid recipients would be appealed. Contact: Nina Rosenberg 617/727-8010.

\* MA \*P /83 (-) Massachusetts is proposing to impose liens on the property of permanently institutionalized recipients.

MA \*P 11/82 (-) Massachusetts has introduced legislation which would require judges to include health insurance maintenance in all support orders for Medicaid eligibles. Contact: Greg Breslin 617/727-3639.

MA \*P 11/82 ( ) Massachusetts has proposed to conduct a mass mailing to absent parents. Contact: Greg Breslin 617/727-3639.

MA \*A 10/82 (-) The Massachusetts legislature enacted a law which expands third party liability efforts by requiring that recipients and insurers provide information on the health insurance coverage of Medicaid recipients (H179). This subject matter is contained in Chapter 367 of the Acts of 1982.

MA \*A 10/82 (-) Massachusetts conducted a mass mailing to all SSI recipients who were covered by Medicare to inquire if they had any Medicare supplemental coverage. This supplemental coverage would then also be primary payor before Medicaid. A second mailing was sent in July 1983 for the same purpose.

MA \*A 7/82 (-) (H 177) The Massachusetts legislature has enacted a law to increase third party liability collection efforts.

MA \*A 7/82 (-) Massachusetts instituted a Third Party Resource Training Program for Child Support Enforcement Workers to increase the number of support (AFDC) cases with the maintenance of health insurance for Medicaid eligibles.

MA \*A 1/82 (-) Massachusetts instituted an enhancement in the Medicaid Claims Processing System by implementing a Selective TPL edit for physician claims.

\* MI \*A 7/83 (-) (HB 4558) Michigan's Appropriations Act contains a provision that requires general assistance recipients to sign a contract to repay general assistance upon receipt of retroactive SSI payments.

\* MI \*A 7/83 (-) (HB 4558) Michigan's Appropriations Act contains a provision which requires recipients to assign rights of recovery. In addition, the recipient shall sign a medical release giving the state the right to review medical information regarding services paid by the state.

MI	*A	/82 (-)	The Michigan Medicaid program held discussions with Michigan Rehabilitation Services on the subject of more effective use of monies for clients enrolled in both agencies' programs. This would have included elimination of possible double billing for services.
MN	*A	3/82 (-)	(HF 2123) The Minnesota legislature enacted a bill to require responsible relatives to pay for the cost of recipient care.
*	MS	*P /83 (-)	(S 2371) The Mississippi legislature introduced a bill which would allow for imposition of liens on recipient property.
	MS	*X 1/82 ( )	(SB 2589) The Mississippi legislature reported the introduction of a bill to require nursing homes to participate in Medicare. This proposal has been dropped.
*	MO	*A 3/83 (-)	Missouri produced and implemented a third party liability training video tape for mandatory training for intake workers (eligibility determination workers).
*	MO	*A 2/83 (-)	Missouri expanded the health insurance information shown on the Medicaid Card.
*	MO	*P /83 (-)	Missouri proposes to enhance third party liability efforts by interfacing applicable Medicaid eligibles with IV-D System.
	MO	*A 12/82 (-)	Missouri has automated the Third-Party Liability process.
*	MO	*A 1/82 (-)	Missouri implemented a TPL operational system to provide more detailed reporting, billing and collection of third party resources.
*	MO	*A /82 (-)	In Missouri, legislation was enacted requiring that medical support provisions be included in support orders originated by State Child Support Enforcement Unit.
	MO	*A /82 (-)	The Missouri legislature enacted legislation to expand third party liability efforts (HB1953).
*	NV	*A 1/82 (-)	Nevada has refined and expanded its criteria for handling TPL cost avoidance and cost recovery.



- \* NH \*A 8/83 (-) (HB 516) The New Hampshire legislature enacted a law which required recipients who receive a settlement from a third party to repay Medicaid to the extent possible. Attorney fees shall not be deducted from the amount due the state.
- \* NJ \*A 10/83 (+) (A 3837) The New Jersey legislature passed a bill to prohibit the imposition of encumbrances or recovery against the estate of a recipient if the amount sought is less than \$500; the estate is less than \$3,000, or there is a surviving spouse or child. This does not apply to incorrect or illegal payments or third party liability.
- \* NM \*A 4/83 (-) New Mexico implemented an automated system which assists providers in recovering TPL payments for claims denied by Medicaid by making third party information available to providers.
- NM \*X 1/82 (-) (HB 126) The New Mexico legislature considered a bill to allow relatives or religious organizations to contribute up to \$300 per month to a nursing home resident, without affecting Medicaid eligibility, and to limit the amount earmarked to defray nursing home costs to 50% of the contribution. This proposal has been dropped.
- NY \*A 9/82 (-) New York implemented a program to recover Medicaid funds from absent parents.
- NY \*A 6/82 (-) New York implemented the Medicare Optimization Project, a program to appeal Medicare denials of nursing home services.
- \* NC \*A 7/83 (-) (SB 23) The North Carolina legislature enacted a law which mandated that SNF participation in Medicare is a required condition of participation in Medicaid.
- \* NC \*P /83 (-) (H 460) The North Carolina legislature reports introduction of a bill which would place a lien on the property of permanently institutionalized nursing home residents.
- ND \*A 1/83 (-) A new third party liability (TPL) system featuring improved screening at the local level, and greater information retrieval capacity and better systems control at the state level has been implemented by North Dakota. The system was phased in from January to July 1983.



\* OH \*A 7/83 (-) (H 291) The Ohio legislature enacted a law which authorized the Department of Public Welfare to develop regulations to recover funds and establish liens against the property of recipients.

\* OH \*A /83 (-) (HB 100) The Ohio legislature enacted a law which increases third party liability efforts.

\* OR \*A 10/82 (-) Oregon conducted an internal reorganization in order to better direct the state's efforts at realization of third party resources.

PA \*A /82 (-) Pennsylvania is developing and improving its third party liability program through its new MMIS system.

SC \*A /82 (-) South Carolina implemented a computer match with the State Retirement System to verify retirement benefits of Medicaid recipients.

SC \*P /82 (-) South Carolina is considering a proposal to recover Medicaid funds from absent parents.

SD \*X /82 (-) South Dakota considered strengthening its third party liability recovery efforts, but the proposal has been dropped.

TN \*A /82 (-) (SB 2235) The Tennessee legislature enacted legislation to increase TPL efforts through subrogation of rights and imposition of a 10% collection fee.

TX \*A /83 (-) Texas is in the process of implementing an automated Post-payment Recovery System. This will enable Medicaid to identify paid claims that may be covered by private insurance, and to expand information files concerning recipients' private insurance. The system should be completed in 1983.

\* UT \*P /83 (-) Utah is proposing to increase third party liability (TPL) collection efforts.

VT \*A 7/82 (-) (H 721) The Vermont legislature passed a law which establishes a fund to receive donations, appropriations and federal matching funds to be used to promote community living programs for the elderly and handicapped.

\* VA \*A /83 (-) The Virginia Medicaid Agency is under a legislative mandate to pursue, to the extent allowed by federal law, the responsibility of relatives of nursing home residents.

- VA \*A /82 (-) The Virginia legislature passed a bill which would require children over 18 to contribute to the cost of care for parents receiving Medicaid benefits. This law will remain on the books unimplemented until such time as federal statute is changed to allow its application.
- VA \*A /82 (-) (HJR 92) The Virginia legislature enacted a bill which requires the agency to study methods to increase third party liability recoveries.
- WA \*A 1/82 (-) Washington has enhanced collections of third-party resources through improved identification of benefits and increased staffing.
- \* WV \*P /83 (-) (SB 51, HB 1741) The West Virginia legislature reports the introduction of bills to increase the state's TPL efforts.
- WV \*P /82 (-) West Virginia is considering a proposal to recover Medicaid funds from absent parents.
- \* WI \*X /83 (-) (AB 502) The Wisconsin legislature considered a bill to require adult children of Medicaid recipients to contribute to the cost of care. Contributions are based on income, ranging from \$3.25 per day for an income of \$30,000 to a maximum that covers the total cost of care for incomes over \$115,000. This proposal did not pass.
- WI \*A 10/82 (-) The State of Wisconsin established a program on a statewide basis to recover Medicaid funds from absent parents. (A limited pilot-project was begun in August 1979.) Full implementation was reached in October 1982.
- WI \*A 5/82 (-) (SB 83) The Wisconsin legislature enacted a law to allow counties that assist in recovering fraudulent Medicaid payments to retain 15% of the amount recovered.

### C. Fraud and Abuse

- \* AL \*P /82 (-) The state will implement a photo ID system. Enabling state legislation was passed in 1980.
- \* AK \*A 8/82 (-) Alaska began sending to recipients, on a sample basis, letters requesting verification that reported services were actually delivered.

- \* AK \*A /82 (-) The Alaska state government established an administrative Fair Hearing Office to deal with fraud and abuse control measures in the AFDC, food stamp and Medicaid programs.
- \* AZ \*A /83 (-) (SB 1279) The Arizona legislature enacted a law which sets sanctions for provider fraud.
- CA \*A 1/83 (-) California requires collection of overpayments found at audit even if they are appealed. If the provider's appeal is successful, amounts due to the provider are returned with interest.
- CA \*A 7/82 (-) California statutes have increased the rate of interest on provider overpayments and now also require interest to be paid on provider underpayments that are appealed.
- CA \*A 5/82 (-) (AB 528) The California legislature enacted a bill that would require providers who have been ordering unnecessary services to receive prior authorization.
- CA \*X 1/82 ( ) (AB 2310) The California legislature reported that a bill had been introduced to prevent providers who act in good faith in making eligibility determinations from having payments withheld. This proposal was dropped.
- CA \*A /82 (-) California law now contains a number of provisions which will enable the Department to more effectively collect overpayments made to Medi-Cal providers, to fine providers who knowingly bill the program improperly, and to expeditiously suspend providers who are abusing the program or patients.

a. Interest and Penalties: Overpayments

This provision authorizes the Department to charge interest and penalties to institutional providers who intentionally overbill the Medi-Cal program. Interest charged on the principal is set at the "pooled money fund" rate; penalties range from 10 percent of the amount of overpayment in simple cases to 25 percent where fraud is involved.

b. Judgements Against Unincorporated Providers

California law authorizes the Department of Health Services to collect overpayments from unincorporated providers, an option that was formerly prohibited by law.



c. Sixty-Day Collection of Overpayments

The law provides for the collection of overpayments to providers after 60 days on the basis of an audit report statement of accountability or demand for payment issued by the Department. A provision of current law is deleted which limits the filing of judgements and liens for the recovery of Medi-Cal overpayments to institutional providers. Further, it provides that, if on appeal, it is found that no overpayment was made to the provider, the Department will reimburse the provider any amount previously recovered plus interest beginning 60 days after issuance of a statement of accountability, demand for payment, or audit which alleges overpayment.

d. Liens Against Personal Property

This provision authorizes the Department to file liens against the personal property of health care providers to recover overpayments.

e. Suspension of Medi-Cal Providers

The law allows expedited suspension of providers who have abused the Medi-Cal or Medicare programs.

f. Inappropriate Billings: Triple Damages

This provision allows the Department to fine providers three times the amount claimed in cases where a provider knowingly bills the program inappropriately.

- \* CT \*A /83 (-) (SSB 850) The Connecticut legislature enacted a bill which provides that persons reporting Medicaid fraud receive 10 percent of any amounts recovered as a result of the report.
- CT \*C /82 (-) The State of Connecticut is considering increasing its Surveillance and Utilization Reporting System (SURS) staff.
- FL \*A 7/82 ( ) The Florida legislature enacted a bill to make information pursuant to fraud and abuse investigations confidential until administrative sanctions are imposed, the case is referred for criminal prosecution, or until ten days after the complaint is found to be without merit.



*	GA	*P	/83 (-)	The Governor of Georgia has proposed that fraud and abuse control efforts be strengthened.
*	IL	*A	/83 (-)	(SB 1079) The Illinois legislature enacted legislation which authorized the Department of Public Aid to develop a post-payment audit and review, on a sampling basis, to verify the delivery of drugs, dentures, eyeglasses, and prosthetic devices.
	IN	*A	7/82 (-)	(SB 299) The Indiana legislature enacted a law which: <ul style="list-style-type: none"> <li>• established a Medicaid fraud control unit;</li> <li>• prohibited providers from requiring payment from a Medicaid recipient, except when a copayment is required by state law; and</li> <li>• imposed sanctions on providers for violations, including: denial of payment for a specified time, denial of provider participation in Medicaid, assessment of fines (not to exceed 3 times the amount of overpayment made to provider), assessment of an interest charge on overpayments.</li> </ul>
*	IA	*A	5/83 (-)	(SF 541) The Iowa legislature enacted a law which established a procedure to set off against an income tax refund the amount owed to the state for public assistance overpayments.
	KS	*A	1/82 (-)	Kansas began requiring that group providers identify the physician performing the service on their claims forms.
	KY	*A	4/82 (-)	(H 536) The Kentucky legislature reports passage of a law to impose sanctions for fraud and abuse by recipients or providers.
	MA	*A	3/83 (-)	In Massachusetts a bill establishing termination as an administrative sanction was passed as Chapter 39 of the Acts of 1983.
	MA	*A	7/82 (-)	(H 181) The Massachusetts legislature enacted legislation to facilitate recovery of overpayments to providers. H181 has become Chapter 368 of the Acts of 1982.

MA \*P 2/82 (-) (H 1164) The Massachusetts legislature reported the introduction of a bill to increase the penalties for fraud by recipients and providers.

MA \*X 2/82 (-) (H 4795) The Massachusetts legislature has reported the introduction of a bill that would make provider fraud a felony offense. This proposal was dropped.

MA \*P /82 (-) Massachusetts is considering a policy change to allow the state to place a lien on provider property, increasing collections from bankrupt providers. Contact: Marcia Kadnoff 617/727-7151.

\* MI \*A 7/83 (-) (HB 4558) Michigan's Appropriations Act contains a provision which requires recipients to assign rights of recovery. In addition, the recipient shall sign a medical release giving the state the right to review medical information regarding services paid by the state.

MI \*A 4/82 (-) Michigan began closely reviewing laboratory services for above average use. A provider suspected of abuse will be referred for possible audit and recovery of funds.

MI \*A /82 (-) (S 611) The Michigan legislature enacted a law authorizing appointment and powers of special investigators to investigate fraud and abuse.

\* MN \*A 6/83 (-) (SF 1234) The Minnesota legislature enacted a law which allowed restriction or suspension of eligibility for up to one year for persons convicted of a criminal offense relating to applying for or receiving medical assistance.

\* MN \*A 5/83 (-) (SF 695) The Minnesota legislature enacted a law which increased from \$250 to \$500 per day the maximum fine for noncompliance with a nursing home violation correction order.

\* MN \*A 5/83 (-) (SF 695) The Minnesota legislature enacted a law which authorized establishing a schedule of fines for nursing homes not in compliance with a correction order.

MN \*A 3/82 (-) (SF 1605) The Minnesota legislature enacted a bill to require annual audits of some nursing homes, at least 5% of which would be randomly selected and 20% selected by various factors.

*	MS	*A	/83 (-)	(S 2410) The Mississippi legislature enacted a law which establishes procedures for the suspension of providers.
*	MO	*A	6/83 (-)	Missouri implemented an Advanced Surveillance and Utilization Review System, which gives more flexible data to enable the staff to better focus in on aberrant providers.
*	MO	*A	6/83 (-)	Missouri implemented a focused Recipient Explanation of Medicaid Benefits Survey which will enable the state to survey by letter patients of an identified aberrant provider.
*	MO	*A	8/82 (-)	Missouri implemented House Bill 1086, which gives the Medicaid agency authority to suspend, revoke, or refuse to enter into a contract with a provider who is identified as having committed fraud or abuse.
				It also establishes the agency's authority to prior authorize certain services before they are paid, and reaffirms, and strengthens its authority to restrict the recipient's number of providers.
*	MO	*A	5/82 (-)	Missouri established relationships with professional boards and other agencies for the exchange of information and the referral of aberrant providers.
	MO	*P	5/82 (-)	Missouri has proposed to require after-the-fact billing of nursing home drugs.
	MO	*A	2/82 (-)	The Missouri legislature passed legislation to institute a lock-out program.
	MO	*P	2/82 (-)	Missouri has proposed to screen data closely for physicians and podiatrists upgrading the level of office visit billed versus the level of visit actually performed.
	MO	*P	2/82 (-)	Missouri has proposed to develop a computer edit to identify those nursing homes reporting no patient surplus.
*	NM	*P	/83 (-)	(SB 26) The New Mexico legislature reports introduction of a bill which would set penalties for providers who fail to reimburse Medicaid upon receipt of third party payments.
	OH	*A	8/82 (-)	Ohio began charging interest on overpayments to providers at three percent above the Federal Reserve discount rate.

*	RI	*P	/83 (-)	(H 5151) The Rhode Island legislature reports introduction of a bill to increase penalties for fraud and abuse.
*	RI	*P	/83 (-)	(H 5858) The Rhode Island legislature reports introduction of a bill to increase fraud and abuse curtailment efforts.
	RI	*A	/83 (-)	(H 7804) The Rhode Island legislature enacted a bill which defines provider fraud and sets sanctions for fraudulent activities.
*	SC	*P	/83 (-)	(S 423) The South Carolina legislature has introduced a bill to establish fraud and abuse rules and sanctions.
	SD	*A	10/82 (-)	South Dakota strengthened procedures to curtail fraud and abuse.
*	TN	*P	/83 (-)	(SB 365, SB 366) The Tennessee legislature reports introduction of a bill to create a fraud control unit.
	VA	*A	2/82 ( )	(HB 187) The Virginia legislature passed a bill which transfers the fraud and abuse unit to the Attorney General's office.
	WA	*A	7/83 (-)	Washington began requiring the identification of the ordering physician on laboratory, x-ray, and prescription claims, and the attending physician on hospital claims.
	WA	*C	/82 (-)	The State of Washington has proposed to establish a peer review process with the Washington State Pharmaceutical Association in order to detect fraud.
	WV	*A	/82 (-)	The West Virginia legislature passed a bill which defines as a felony any false statement, misrepresentation, or concealment of facts in order to obtain Medicaid eligibility.
	WI	*P	/83 (-)	Wisconsin is proposing to establish a policy of fining an ICF or SNF between \$10 and \$100 for each day that it refuses to recover Medicare costs or obtain Medicare certification. Target date is 1984.



#### D. Claims Processing

- \* AZ \*A /83 (-) (SB 1279) The Arizona legislature enacted a law which requires payments to be made within 45 days of date of claim or date of eligibility, whichever is later.
- \* AZ \*A /83 (-) (SB 1279) The Arizona legislature enacted a law which establishes procedures for handling erroneous claims.
- \* CA \*A /83 (-) (AB 531) The California legislature enacted a law which established time limits on demands for repayment of fees overpaid to providers and establishes procedures for audit appeal and demands for overpayments.
- \* GA \*P /83 (-) The Governor of Georgia has proposed that improvements be made in claims review and in the recovery of overpayments.
- \* IL \*A 12/83 (-) Illinois began paying claims from certain pharmacies through tape-to-tape billings.
- IL \*A /82 (+) (HB 2597) The Illinois legislature enacted a bill which provides that claims not paid within 60 days accrue one percent interest per month.
- \* IA \*A 6/83 (+) Iowa extended the time limit for providers to file claims to 365 days. (This time limit was reinstated, since the April 1982 change to a 150-day limit proved unworkable.)
- IA \*A 4/82 (-) Iowa required providers to submit claims within 150 days of date of service (previously 365 days).
- \* KS \*A 9/83 (-) Kansas began using the HCFA 1500 claim form for all provider claims.
- \* KS \*A 5/83 (-) Kansas began requiring that claims relating to chronic renal dialysis have documents attached proving that the recipient is no longer eligible for Medicare coverage of dialysis. In addition, claims for services provided in the first three months of maintenance dialysis for CRD recipients who did not have self dialysis training in the first three months of maintenance are to have a copy of an evaluation of the recipient for self dialysis training attached.

*	KS	*P	/83 ( )	Kansas hospitals will be converting to the UB-82 claim form effective January 1, 1984.
	KY	*A	6/82 (-)	Kentucky's MMIS was certified June 1982. (Contact: Ronnie Cohorn 502/564-7540).
	KY	*A	4/82 (-)	(S 163) The Kentucky legislature enacted a law creating mechanisms to collect overpayments.
	LA	*A	/82 ( )	(BH 1598) The Louisiana legislature passed a law which defines the state's contractual relationship with its fiscal intermediary.
*	MA	*A	1/83 (-)	Massachusetts implemented direct recovery from the Medicare intermediary for erroneously paid Medicare Part B services.
*	MA	*P	12/82 (-)	The Massachusetts legislature has reported that a bill has been introduced to amend Chapter 368 of the Acts of 1982 which will further clarify technical provisions of the chapter which is designed to facilitate recovery of overpayments to providers.
	MA	*X	1/82 (-)	(S 636) The Massachusetts legislature reported that a bill has been introduced to require providers to report service procedure codes on claims forms. This proposal was dropped.
	MA	*X	1/82 ( )	(S 466) The Massachusetts legislature reported that a bill has been introduced to require providers to submit bills no later than 6 months after service has been delivered. This bill was not enacted.
*	MI	*A	7/83 (-)	(HB 4558) Michigan's Appropriations Act contains a provision that requires providers to submit bills within 12 months of the date of service or forfeit right to payment.
*	MI	*A	7/83 (-)	(HB 4558) Michigan's Appropriations Act contains a provision that allows reduction or suspension of payments to institutional providers who are cost settled who do not submit cost reports within 90 days of the end of their fiscal year.
	MI	*A	/82 (-)	The State of Michigan began meetings to implement a "cross-over" claim system to handle Medicaid/Medicare/Blue Cross-Blue Shield of Michigan liability.

*	MO	*P	9/83 (-)	Missouri is developing an automated approach to provider enrollment, recipient enrollment, claims processing and reporting to support the competitive health care system demonstration project for AFDC recipients in the Kansas City area.
*	MO	*A	9/83 ( )	Missouri modified the claims processing system to accommodate 5-digit diagnosis codes.
*	MO	*P	8/83 (-)	Missouri proposes to build an audit to enforce the post-operative policy that follow-up care for 30 days after surgery is included in the surgery fee.
	MO	*A	2/82 (-)	Missouri expanded its pre-payment cost avoidance edits.
*	NE	*A	5/83 (-)	Nebraska adopted procedures for sampling and extrapolation to determine overpayments to Medicaid providers. This is a method of auditing a provider's claims in which a sampling of his/her submitted claims is taken and results are extrapolated to the entire universe of services for which the provider has been paid during the audit period. (The provider may subsequently request a hearing and submit an independent 100 percent audit of Medicaid payments during the audit period.)
	NV	*A	4/82 (-)	Nevada reduced limit on submission of claims to 90 days, with certain exceptions for other insurance and retroactive eligibility. (Previously, Nevada had proposed a reduction from 12 to 6 months.)
	NH	*C	/82 (-)	The State of New Hampshire is considering limiting the period during which providers must submit their claims to 90 days from the date of service.
*	NJ	*A	/83 (-)	New Jersey automated its recalculation of nursing home rates following audits.
	NJ	*A	1/82 (-)	New Jersey began using single-ply Medicare-Medicaid claim forms (HCFA 1500).
	NM	*A	6/82 (-)	New Mexico reduced the time period during which Medicaid claims may be submitted, from a maximum of 365 to 120 days from date of service.



ND	*A	7/82 (-)	Optical Character Recognition (OCR) equipment was installed to read claims and input data to North Dakota's MMIS.
OH	*X	2/82 (-)	(SB 472) The Ohio legislature reported introduction of a bill to appoint a medical assistance pharmacy ombudsman to assist providers in claims processing. This bill was not enacted.
OK	*A	/82 (-)	The state is developing a tape-to-tape billing system for hospital charges. Some hospitals began billing by tape in 1982.
OR	*A	6/82 (-)	Oregon's MMIS system was federally approved and became operational on June 30, 1982.
*	SC	*P /83 (-)	South Carolina is considering a proposal to discontinue paying non-assigned Medicare crossover claims.
TN	*A	7/82 (-)	Tennessee no longer will reimburse for Medicare cross-over payment of the Part A hospital deductible.
*	VA	*A /83 (-)	Virginia implemented tape-to-tape billing by hospitals.
WA	*A	10/82 (-)	The State of Washington signed a new contract for an enhanced MMIS, which includes improved capabilities for claims processing, surveillance and utilization review and program management. This contract was implemented on October 1, 1982.
WA	*A	1/82 (-)	The state implemented an exam entry system for claims processing allowing adjudication of claims at the point-of-entry into the MMIS.
WV	*A	11/82 (-)	West Virginia is planning to implement tape-to-tape billing for all provider types. It is phasing in tape-to-tape billing for pharmacies.



## E. Purchase of Services

- \* AL \*A /83 (-) In Alabama laws were enacted which: (1) mandated that contracts for the purchase of services that are required to be competitively bid shall be awarded to the bidder whose proposal is most advantageous to the state (SB11XX); and (2) defined competitive bidding procedures (H 373). Alabama purchases eyeglasses, fiscal intermediary services and hospital utilization review services through competitive bidding.
- CA \*A 1/84 (-) California commenced operation of a prescription drug volume purchasing program. Fifty drugs have been selected for inclusion in the program, and contracts are being awarded to sixteen companies to provide these drugs. Each drug will be supplied by between two and five different firms. The manufacturers who have contracted with the state to provide specific drugs will return a rebate to the state for those drugs purchased by the state for Medicaid recipients. Contracts were awarded to those manufacturers offering the lowest net prices to the state (the current price minus the rebate). Contracts stipulate that rebates will increase with prices, in order to maintain the same net prices to the state during the contract period. Pharmacists will be required to provide the designated brands of the contracted drugs to Medicaid recipients, unless another drug is prior authorized.
- CA \*P /83 (-) California is developing proposals to "volume purchase," on a bid or negotiated basis, medical supplies and appliances, durable medical equipment, laboratory services, eyeglasses and other "product-type" health care services. Such contracts may be exclusive. A report to the legislature demonstrating the cost-effectiveness of a proposed volume purchase contract is required before the Department is authorized to execute such a contract. California has adopted a drug volume purchasing program, which will be implemented January 1984.

CO	*C	/83 (-)	Colorado is considering a change in its durable medical equipment (DME) program in which the state would retain ownership of DME. Contracts would be signed with various providers around the state to monitor use of equipment, collect it when it is no longer needed, store it, refurbish it and distribute it. Currently, DME becomes the property of the recipient.
CT	*X	/83 (-)	The Connecticut legislature reported that a bill was introduced to establish competitive bidding for eyeglasses and other corrective vision aids (H9010X). This bill was not passed. The single state agency then proposed adopting an eyeglass volume purchasing program by regulation. However, it was not approved by the Legislative Review Committee and will, consequently, be dropped.
CT	*X	/82 (-)	The State of Connecticut considered the bulk purchase of durable medical equipment. However, this was dropped.
*	FL	*A 7/82 (-)	Florida has contracted for emergency and non-emergency medical transportation by competitive bid in certain areas of the state.
*	IL	*C /83 (-)	Illinois is considering the volume purchase of laboratory services and/or optometric supplies.
*	IA	*P /83 (-)	Iowa is considering a proposal to enter into arrangements for the bulk purchase of durable medical equipment.
	IA	*P /83 (-)	Iowa is considering a proposal to enter into arrangements for the bulk purchase of optometric supplies.
	IA	*P /83 (-)	Iowa is considering a proposal to enter into arrangements for the bulk purchase of hearing aids.
KS	*C	1/83 (-)	Kansas is considering letting a contract, possibly through a competitive bidding process, for administration of a wheelchair loan closet. Wheelchairs would be picked up, reconditioned, stored and reissued to adult care home residents in order to reduce the number of new wheelchairs purchased.
KS	*X	/82 (-)	The state of Kansas proposed to enter into an arrangement for the bulk purchase of hearing aids. This proposal has been dropped.

KS	*C	/82 (-)	Kansas is considering the bulk purchase of durable medical equipment, medical supplies, and dentures. However, in 1982 volume purchase of wheelchairs was considered and rejected.
* MA	*P	1/84 (-)	Volume purchasing of wheelchairs under the Durable Medical Equipment Program is being proposed in Massachusetts.
* MA	*C	/84 (-)	Massachusetts is considering the volume purchasing of numerous durable medical equipment items and of orthotics, in addition to a proposal to volume purchase wheelchairs.
* MA	*C	/84 (-)	Massachusetts is considering the volume purchasing of taxi cab services on a regional basis under the Transportation Services Program.
MA	*X	2/83 (-)	Massachusetts considered volume purchasing of dental crowns. (Estimated annual savings of \$300,000.) This proposal was dropped.
MI	*P	4/82 (-)	The State of Michigan is considering the volume purchase of laboratory services and a manufacturer rebate plan for certain drugs.
MI	*X	/82 (-)	The State of Michigan was considering the volume purchase of hearing aids. However, the hearing aid proposal has been dropped.
* MN	*A	/83 (-)	(HF 1114) The Minnesota legislature enacted a law to require the volume purchase of oxygen. Implementation will begin in 1984.
MN	*A	3/82 (-)	(HF 2123) The Minnesota legislature enacted a law to require the state to enter into a volume purchasing arrangement for eyeglasses, hearing aids, and durable medical equipment. This has been implemented.
MO	*P	4/82 (-)	Missouri has proposed to pursue rebate arrangements based on claims volume by drug or manufacturer. The State is currently in contact with four drug manufacturers, but no agreements have yet been reached.
NE	*P	/82 (-)	Nebraska is considering a proposal to enter into bulk purchasing arrangements for certain goods.



NV	*A	10/83 (-)	Nevada began to purchase non-hospital lab services through sole source contracts with two private laboratories for provision of all covered lab procedures within two geographic areas: the Reno area, where one provider will serve three counties; and the Las Vegas area, where one provider will serve Clark County and nearby locations. The rest of the state will continue to use a fee-for-service approach.
NV	*A	1/82 (-)	The State of Nevada has reinstituted a statewide inventory system for durable medical equipment which the state has purchased and provided to Medicaid recipients.
*	NH	*C /83 (-)	New Hampshire is considering the bulk purchase of eyeglasses.
*	NJ	*A 7/83 (-)	New Jersey has instituted a per diem incentive for long term care facilities which have entered into a cooperative buying arrangement with either an agency-approved group purchasing firm or with a group purchasing firm offering prices comparable to those on the agency's approved list.
	NJ	*C /82 (-)	New Jersey is considering competitive bidding for selecting providers of independent laboratory services.
*	NY	*C /83 (-)	New York State is considering the volume purchase through competitive bidding of a number of goods and services, including prescription drugs, DME, eyeglasses, hearing aids and independent laboratory services.
*	NC	*A 7/83 (-)	(SB 23) The North Carolina legislature enacted a law which authorized volume purchase or single source procurement of medical equipment, supplies and appliances.
	ND	*C 6/82 (-)	North Dakota is considering a competitive bidding process for the purchase of eyeglasses.
	ND	*C 6/82 (-)	North Dakota is considering a competitive bidding process for the purchase of hearing aids.
*	OR	*A 10/83 (-)	Oregon entered into a contract for the purchase of ophthalmic materials. Practitioners may order lenses and frames from the lab with which the state has contracted, or they may order from other vendors. However, the state will pay no more than the contracted rate.



- \* PA \*C /83 (-) Pennsylvania is considering the volume purchase, through competitive bidding, of high volume goods and services. Being considered are: medical services such as eyeglasses and orthopedic shoes, independent laboratory services and drugs. This initiative was recommended by the Governors' Health Care Cost Containment Task Force. The target date is February 1984.
- \* WI \*C /83 (-) Wisconsin is considering competitive bidding for the selection of providers of independent laboratory services and of medical devices.
- WI \*A 4/82 (-) The State of Wisconsin implemented a volume purchase plan for eyeglasses, effective April 1982.

#### **F. Other Administrative/Management Approaches**

- \* AK \*A 7/82 (-) Alaska shifted the responsibility for all prior authorization of non-emergency transportation to the fiscal intermediary.
- AK \*A 7/82 ( ) (SB 817) The Alaska legislature passed a law which prioritizes all Medicaid eligibility groups and service groups; this priority list will be used, in the event of a budget shortfall, to determine which service and eligibility groups will be dropped.
- \* AZ \*A /83 ( ) (SB 1340) The Arizona legislature enacted a law which sets amount of contributions to state for AHCCCS by newly formed La Paz County.
- \* AR \*A /83 (+) (HR 12) The Arkansas legislature enacted a law that mandated a study by the Budget Analysis Division of the Department of Human Services to determine differences in nursing home reimbursement rates between Medicaid and private pay patients. The findings will be reported to the legislature's Committee on Aging.
- \* CA \*A 1/84 (-) (AB 1593) The California legislature required acute care hospitals to obtain separate licensure in order to provide certain nursing services under Medi-Cal.

- \* CA \*A 8/83 ( ) (AB 1167) The California legislature enacted a law which provided that contracts negotiated for inpatient hospital services entered into after January 1, 1984 and all contracts for services other than inpatient hospital be open to inspection one year after they are fully executed.
  
- CA \*A /83 (-) The State of California implemented a voluntary quality assurance program for the state's prepaid health plans. The design of this program is based on the results of the state PHRED project, an 1115 waiver project which recently was completed.
  
- \* CA \*A /83 ( ) The California legislature established a legislative Joint Committee on Medical Oversight to monitor the implementation and impact of recent legislation affecting the Medi-Cal program. It also will monitor the awarding of a fiscal agent contract. The Committee will terminate at the close of the legislature's 1983-84 regular session.
  
- \* CA \*A /83 (-) (AB 490) The California legislature enacted a law which extended to June 30, 1984 the program under which the state is at risk for excess costs of services for county/state contracts for medically indigent adults (MIAs).
  
- \* CA \*A /83 ( ) (AB 961) The California legislature enacted a law which required the Medical Assistance Commission to report to the legislature on inpatient hospital contracts by February 1, 1984.
  
- \* CA \*A /83 (-) (AB 1734) The California legislature exempted from CON process those free-standing outpatient surgery units that only perform cataract surgery for Medi-Cal recipients. And, exempted hospitals from preexisting obligations to serve Medi-Cal if they serve members of an HMO that has negotiated to contract for Medi-Cal services but has not yet obtained a contract.
  
- \* CA \*A /83 (-) (SB 228) The California legislature required development of an administrative cost control plan for the AFDC Food Stamps, and Medi-Cal programs.
  
- \* CA \*A /83 ( ) (AB 1380) The California legislature enacted a law to allow pharmaceutical providers to set off underpayments against demands for return of overpayments.

- \* CT \*A 10/83 ( ) (SSB 740) The Connecticut legislature passed legislation requiring the Commissioner of Income Maintenance to provide, upon request, a written explanation of which costs are included or excluded on a reimbursement rate paid to a provider.
- \* CT \*A 10/83 (-) (SSB 850) The Connecticut legislature passed legislation requiring a nursing home to reserve the bed of a hospitalized Medicaid recipient for the number of days in which reimbursement is provided by the state.
- \* CT \*A 7/83 ( ) (HB 8008X) In special session, the Connecticut legislature passed legislation establishing a Medicaid Cost Containment Study Commission to report to the legislature by 1/10/84.
- \* CT \*A 7/83 ( ) (HB 2003X) In special session, the Connecticut legislature established a task force to study self-pay rates in nursing homes and analyze the relationship of self-pay rates to Medicaid rates.
- \* CT \*A 1/82 (-) The Connecticut Medicaid Agency has been reviewing, rewriting, and re-issuing its Medical Assistance manual. This has been a gradual process, but is now virtually completed.
- \* FL \*P /83 (+) (HB 929) The Florida legislature reports introduction of a bill to require nursing homes to inform recipients of the fifteen-day reserve bed policy.
- \* FL \*P /83 ( ) The Florida legislature reports introduction of a bill that would require for a license that hospitals cannot refuse admission to Medicare/Medicaid recipients solely on the basis of their payment source.
- \* FL \*P /83 (-) (HB 324) The Florida legislature reports introduction of a bill to require CON applications to designate a percentage of a facility's beds for Medicaid recipients.
- \* FL \*X /83 (-) (HB 1177) The Florida legislature considered a bill which would require that hospitals cannot deny admission to Medicaid or Medicare recipients, if less than 10 percent of that facility's beds are occupied by Medicaid recipients. This proposal did not pass.



- FL \*A 3/82 (-) In March, a comprehensive Medicaid Pre-Service Training Program was disseminated to Florida's regional districts. Although designed for Medicaid staff, certain components were easily adopted in provider training. The curriculum is currently being updated and redesigned into self-paced instructional materials. (Contact: Martha Larson 904/488-8291)
- \* HI \*A /83 (-) The Hawaii legislature enacted legislation mandating a \$25 million cutback in Medicaid funds for Fiscal Year 1984, and a \$39 million cutback for Fiscal Year 1985.
- HI \*A 1/82 (-) Hawaii completed a total rewrite of its Medicaid rules with the assistance of HCFA, making the language clearer and easier to understand.
- \* IA \*A 5/83 (-) (HF 196) The Iowa legislature enacted a law which authorized the creation of the Health Data Commission to gather and publicize information from hospitals and third party payors.
- \* ME \*A 5/83 (-) (SB 466) The Maine legislature enacted a law which allowed unlicensed personnel who have received appropriate training to administer medications to residents of group home ICFs/MR.
- \* ME \*A 4/83 ( ) (SB 460) The Maine legislature enacted a law which required hospitals to inform patients that it will provide an itemized bill upon their request. The request may be made up to seven years after discharge and the hospital shall provide the itemized bill within 30 days of the request. Beginning July 1, 1985 hospitals are required to itemize nursing services.
- \* MD \*A 1/83 (-) Maryland revamped and revised its Medicaid dental regulations. It separated out all exceptional regulations pertaining specifically to recipients under 21 and transferred them to the EPSDT program. The remaining regulations, for adults 21 years and older, were revised as follows:
- complete radiographic surveys and the full series of x-rays of the mouth are limited in frequency to no more than once every three years (exception: for traumatic injuries, a maximum of four panoramic radiographs will be covered);



- all root canal therapies and apicoectomies must receive prior authorization (previously prior authorization was required only when more than one root canal procedure was performed at a time);
- Dentures which are lost, stolen or broken will not be replaced prior to one year from placement, and rebasing will be included in the six months of aftercare and no more than once every two years thereafter.

- \* MD \*A 1/83 ( ) Maryland reorganized its vision care regulations, separating out those exceptional services pertaining only to individuals under 21, and including them with the EPSDT regulations. Since non-EPSDT recipients may undergo visual examinations only once every two years and EPSDT recipients once a year, it was established that any person under 21 who is seeking an exam more than one year but less than two years from his previous exam must first receive a vision screening to ascertain whether an exam is needed. It was also determined that optometrists may provide vision screening services, although they will not be reimbursed for providing the examinations.
- \* MD \*A 1/83 (-) Maryland separated out from its Medicaid regulations any exceptional rules pertaining specifically to individuals under 21 and placed them under the EPSDT program.
- \* MD \*A /83 ( ) (SB 196) The Maryland legislature enacted a law which revises the administrative appeals process for nursing homes.
- \* MD \*P /83 ( ) (SB 593) The Maryland legislature reports introduction of a bill to require nursing homes to submit annual cost reports.
- MD \*X 3/82 (+) (SJ 1026) The Maryland Senate reported the introduction of a resolution to require nursing homes to inform residents of the availability of the monthly personal allowance. This was later dropped.
- MD \*X 2/82 (-) (HB 1026) The Maryland legislature reports introduction of a bill to require that nursing homes have an equal number of Medicaid and private pay patients. This proposal was dropped.

MA	*P	1/82 ( )	(S 595) The Massachusetts legislature reported that a bill has been introduced to require that Medicaid funds for transportation and health aide services be transferred to the Department of Elder Affairs.
MA	*A	/82 (-)	In fiscal year 1982 (July 1, 1981-June 30, 1982), the Massachusetts Department of Public Welfare started making recoveries on PSRO determinations of medical necessity for hospital stays. Previously, the Department only recovered for PSRO determinations of an administrative nature (e.g., leave-of-absence days).
MA	*A	/82 (-)	In fiscal year 1982 (July 1, 1981 - June 30, 1982), the Massachusetts Department of Public Welfare will pursue recoveries through the Case Management Screening Program for monies paid on behalf of Medicaid patients inappropriately or improperly placed in a nursing home.
*	MI	*A 7/83 (-)	(HB 4558) Michigan's Appropriations Act contains a provision that requires the Department of Social Services to evaluate the provision and funding of alternatives to nursing home care by June 2, 1984.
*	MN	*A 7/83 ( )	The Minnesota legislature enacted a law which prohibits practitioners participating in the General Assistance Medical Care Program (GAMP), a state-only funded program, from imposing on the recipient any additional charges, that is, they must accept the state's payment as payment in full. This parallels Medicaid requirements.
*	MN	*A 6/83 (-)	(SF 1234) The Minnesota legislature enacted a law which required counties to pay their portion of Medicaid costs in advance, based on prior month expenditures.
*	MN	*A 5/83 (-)	(SF 695) The Minnesota legislature enacted a law which authorized counties to contract with acute care facilities to allow discharge planners to perform preadmission screening functions.
*	MN	*A 5/83 ( )	(SF 695) The Minnesota legislature enacted a law which established Interagency Board for Quality Assurance to monitor nursing home care. The first report to the legislature is due on January 15, 1984.

- \* MN \*A 5/83 (-) (SF 695) The Minnesota legislature enacted a law which established a Legislative Commission on Long Term Health Care to monitor quality of care, study alternative services, and study alternatives to Medicaid funding. Report due by January 1, 1985.
- \* MN \*P /83 (+) (HF 821) The Minnesota legislature reports introduction of a bill to require that clinic services be under the direct supervision of a physician.
- \* MN \*P /83 (-) (SF 70) The Minnesota legislature reports introduction of a bill to limit state disbursement of funds to once in a 30-day period.
- \* MN \*P /83 (-) (HF 497) The Minnesota legislature reports introduction of a bill to require counties to pay in advance their portion of Medicaid costs.
- \* MN \*P /83 (-) (HF 490) The Minnesota legislature reports introduction of a bill to establish rules to determine county of financial responsibility.
- \* MN \*A /83 (-) The Minnesota legislature granted authority to the executive branch to make modifications in the General Assistance Medical Care Program (GAMP), a state-only funded program, in order not to exceed appropriated funds. It may not, however, cut funds for psychiatric hospital services by more than 45%, general hospital services by more than 35%, and other providers' services by more than 25%. During the period of July 1984 to July 1985, these percentages would be cut in half.
- \* MN \*A 7/83 (-) Minnesota is modifying its nursing home program in several ways. It has moved to a prospective reimbursement system (see Reimbursement subsection), and is attempting to channel long term care patients into alternatives to institutionalization where appropriate. It has doubled its expenditures on alternative care and has implemented a number of demonstration projects. It has also established a moratorium on certification of additional nursing home beds (HF 670, SF 695), and has appointed an interagency board for quality assurance, to insure continued quality of care in nursing homes.
- \* MO \*A 6/83 (-) Missouri initiated user language, statistical analysis, and report writing systems to improve management controls.



MO	*A	6/82 ( )	Missouri has revised certification criteria (1M.64 form) for skilled nursing and intermediate care. The Division of Aging has the lead on this project.
* MT	*A	/83 (-)	(SB 4X) The Montana legislature enacted a law to require counties to pay five percent of the state share of Medicaid costs.
NE	*A	7/84 (+)	(L522) The Nebraska legislature enacted a law which will eliminate county financial participation. The state will assume financial and administrative responsibility for all medical and welfare programs. The change in financial responsibility will be phased in over three years, with the counties' participation being reduced by one-third each year. In 1983, the state took over administrative responsibility. A concurrent requirement, enacted in separate legislation, will give the counties responsibility for General Assistance programs.
* NE	*A	5/83 ( )	Nebraska implemented a new form for its long term care provider agreement.
* NE	*A	/82 (-)	Nebraska recodified its policies in regard to psychiatric services.
* NV	*A	/82 (-)	Nevada modified its system of monitoring program expenditures by reducing the frequency from once a week to once a month. the monitoring of expenditures was initiated in October 1981 in response to a state statute prohibiting the agency from requesting a supplemental appropriation during the FY 1982-83 biennium.
* NH	*A	10/81 (-)	The New Hampshire Medicaid agency assumed the functions previously performed by PSROs with regard to SNFs and ICFs.
NJ	*P	2/82 (+)	(SCR 68 and SCR 4) The New Jersey legislature reports the introduction of bills to establish a commission to study the state's Medicaid administrative structure.
NM	*A	/82 (+)	The New Mexico legislature created a Medicaid contingency fund for the purpose of alleviating the effects of federal reductions when and if it becomes necessary. However, it cannot be used unless cost containment measures have been implemented.



- \* NY \*A /82 (-) In New York, legislation established the requirement that all contracts and rates for personal care services be approved by the Department of Social Services and the Director of the Division of the Budget.
- \* NC \*A 7/83 ( ) (SB 518) The North Carolina legislature enacted a law which authorized the creation of the legislative commission on medical care cost containment. Specific items to be addressed include: hospital rate review, CON, and hospital bad debts.
- \* ND \*A /83 ( ) (SCR 4054) The North Dakota legislature enacted a law which mandates a study by the Legislative Council of the variation between Medicaid and self-pay nursing home rates. The study will be made over the course of one and one-half years.
- \* OH \*A /83 (-) (HB 100) The Ohio legislature enacted a law which grants broader authority to the Department of Public Welfare to limit coverage, benefits and reimbursement.
- \* PA \*A 1/83 (-) Pennsylvania modified its definition of Skilled Nursing Facilities (SNFs). This resulted in some SNF patients being recertified for ICF care.
- \* RI \*P /83 ( ) (H 5815) The Rhode Island legislature reports introduction of a bill to prevent nursing homes from discriminating against Medicaid applicants.
- \* RI \*P /83 ( ) (H 5280) The Rhode Island legislature reports introduction of a bill to authorize the Director of Business Regulation to approve hospital operating budgets.
- \* SC \*A 6/83 (-) (SB 132) The South Carolina legislature enacted legislation that establishes the State Health and Human Services Finance commission to administer Medicaid, operate the Cooperative Health Statistics Program, and administer the Social Services Block Grant Program. Among its duties, the Commission is responsible for preparing and approving state and federal plans, reviewing and monitoring programs, and contracting for eligibility determination and MMIS.

- \* SC \*A 6/83 (-) (HB 2912) the South Carolina legislature resolves that the Department of Social Services assure that Medicaid expenditures be kept at an amount that guarantees receipt of a rebate for federal funds withheld. The State treasurer may loan on an interest bearing note, an amount which does not exceed the amount of Medicaid funds temporarily withheld by the federal government.
- SC \*P /82 ( ) South Carolina proposes to shift responsibility for the Medicaid program from its Department of Social Services to a new agency, the Health and Human Services Finance Commission.
- \* SD \*A /83 (-) (HB 13333) The South Dakota legislature enacted a law which required that counties contribute to the state for the first 30 days of hospital care for Medicaid recipients. Each county pays a proportional share based on population. The amount of the contribution equals the cost of 30 days of hospital care less: federal share; unused county contributions; available malt beverage funds; and, state general funds appropriated for Medicaid hospital services.
- \* TN \*P /83 ( ) (SB 7) The Tennessee legislature reports introduction of a bill to require providers to submit itemized bills to recipients.
- \* TN \*P /83 ( ) (HB 683, S 782) The Tennessee legislature reports introduction of a bill to require thirty-day notice before modifying the drug formulary.
- \* TN \*P /83 ( ) Tennessee proposes to transfer responsibility for issuing Medicaid cards to AFDC recipients from the Department of Human Resources to the Department of Health/Medicaid.
- TX \*A 3/83 (-) Texas rewrote and distributed its provider manuals for a number of provider groups.
- TX \*A /82 (-) Texas consolidated standards of participation for SNFs and ICFs.
- \* VA \*A 2/83 ( ) (SJR 54) the Virginia legislature enacted a law which encouraged the Department of Health to provide Medicaid coverage to otherwise eligible residents of publicly operated homes for adults.

### III. ELIGIBILITY

#### A. Coverage of Optional Groups

- AK \*A 11/82 (+) Alaska expanded coverage to include all individuals under 21 who would be eligible for AFDC except that they do not meet the AFDC definition of a dependent child. Previously, only children in ICFs/MR, in foster homes, in psychiatric institutions, and AFDC recipients between 18 and 21 were covered. Medicaid will now cover children living in two-parent households, children in subsidized adoptions, and the unborn as well.
- \* AK \*A 10/82 (+) Alaska added coverage of pregnant women for the full nine months of their pregnancy.
- CA \*A 1/83 ( ) The state-funded Medically Indigent Adult (MIA) eligibility category was eliminated, effective January 1, 1983. Exempted are pregnant women and residents of SNFs/ICFs. County governments have assumed responsibility for approximately 270,000 persons statewide under the auspices of Welfare and Institutions Code 17000. Counties are empowered to determine the services provided, and by whom (and where) they are provided.

The State will provide ongoing block grant funding to counties to meet the costs of providing services to this new population. Funding for the last six months of FY 1982-83 is set at 70 percent of the amount that would have been expended under Medi-Cal if these persons' eligibility had continued. Funding will be allocated to counties based on historical expenditures for MIAs from each county. Counties are required to submit plans to the Department of Health Service detailing how services are to be provided, and counties are prohibited from reducing county spending for inpatient/outpatient and public health services.

Counties with populations under 300,000 (of which there are 43) are provided the option of contracting back to the Department of Health Services for the provision and payment of care for MIA patients.



CA	*A	1/83 (-)	California has eliminated Medi-Cal coverage for adults receiving state only AFDC-U or Emergency Services Assistance.
CO	*X	2/82 (+)	(SB 125) The Colorado legislature reported introduction of a bill to create a medically needy program limited to the following services: inpatient and outpatient hospital, home health, clinic, lab and x-ray, prescribed drugs, physician, and rural health clinic. This proposal has been dropped.
CT	*X	/82 (-)	The State of Connecticut considered limiting eligibility to required coverage groups, eliminating caretaker relatives of individuals under 21 and individuals under 21 who are not categorically eligible. This proposal was dropped.
DE	*C	/83 (-)	Delaware is considering dropping coverage of 18- to 21-year-old AFDC and general assistance categories.
DE	*A	9/82 (+)	Delaware added coverage of children for whom the state makes adoption assistance or foster care maintenance payments under Title IV-E of the Social Security Act.
DE	*A	8/82 (-)	Delaware deleted coverage of individuals eligible for but not receiving AFDC, SSI, or optional state supplementary payments.
*	GA	*A 7/83 (+)	Georgia added coverage of pregnant women expecting their first child.
*	GA	*A 10/82 (+)	Georgia added coverage of children for whom the State makes adoption assistance payments under Title IV-E of the TEFRA Act.
*	GA	*A 7/82 (+)	Georgia added coverage of children for whom the State makes foster care maintenance payments under Title IV-E of the TEFRA Act.
IN	*X	1/82 (+)	(HB 1119) The Indiana legislature reported that a bill had been introduced to provide eligibility to pregnant women whose expected children would be eligible if already born. Pregnant women would be eligible only for those Medicaid services of direct benefit to expected children. This proposal was dropped.
IA	*A	7/82 (+)	Iowa added coverage of the non-qualifying parent in AFDC-unemployed parent families.



MA	*A	12/82 (+)	In Massachusetts, another larger class of individuals, for whom cost of living increases since 1977 would render them ineligible, were added to those eligible for Medicaid coverage with no spend-down under the provisions of the Pickle Amendment.
* MI	*A	7/83 (+)	(HB 4558) Michigan's Appropriations Act contains a provision to cover the mother of an unborn child for AFDC and Medicaid upon proof of pregnancy, if all other eligibility factors are met. The state will pay for the pregnancy examination if she is unable to provide documentation.
MN	*A	/82 (+)	(HF 1690) The Minnesota legislature enacted a law to include children receiving foster care maintenance payments or adoption assistance under Title IV-E as Medicaid eligibles.
MN	*A	/82 (+)	Minnesota instituted Medicaid coverage of women whose pregnancy has been medically verified and who would be eligible for AFDC if the child were born and living with the mother.
* MS	*A	7/84 (+)	(S 2390) The Mississippi legislature enacted a law which will provide prenatal care and delivery services for medically needy pregnant women and unborn children.
* MS	*A	7/84 (+)	(S 2390) The Mississippi legislature enacted a law which will provide ambulatory services for medically needy children under 18.
* MS	*X	/83 (+)	(H 480) The Mississippi legislature has introduced a bill which would provide home- and community-based services for the aged, blind and disabled medically needy. The bill did not pass.
* MS	*X	/83 (+)	(H 936) A bill has been introduced for consideration by the Mississippi legislature which would add coverage of medically needy persons over 65. The bill did not pass.
MS	*A	2/82 (+)	(HB 233) The Mississippi legislature enacted a law which provides eligibility to pregnant women and foster care children. Coverage of pregnant women replaces coverage of unborn children.
MS	*A	1/82 (-)	Mississippi dropped coverage of the optional AFDC 18- to 21-year- old group.

	NV	*P	/82 (+)	Nevada proposed to extend Medicaid eligibility to pregnant AFDC women as soon as pregnancy is medically verified, even though an AFDC grant is not provided until the sixth month. Savings anticipated by reducing the risk of complicated pregnancies, high risk and/or defective newborns.
*	NH	*A	4/82 (-)	New Hampshire dropped coverage of 18- to 21-year-old AFDC recipients.
	NJ	*X	2/82 (+)	(A 693 and AB 7) The New Jersey legislature reported the introduction of bills to create a medically needy program. This proposal was dropped.
	NJ	*P	2/82 (+)	(SCR 82 and S 1060) The New Jersey legislature reported the introduction of a resolution bill to study the feasibility of providing Medicaid eligibility to certain handicapped children.
*	NM	*A	12/83 (+)	New Mexico has extended Medicaid coverage to women pregnant for the first time from the point at which the pregnancy is medically verified.
	NM	*A	7/82 (-)	New Mexico eliminated coverage of children between the ages of 18 and 20 who would be eligible for AFDC except for the fact that they do not attend school.
	NC	*A	3/82 (+)	North Carolina began covering pregnant women. A woman eligible in this category would meet AFDC categorical eligibility requirements if there is no dependent child already in her care.
	NC	*A	2/82 (-)	North Carolina eliminated coverage for 19- and 20-year-old AFDC recipients in the medically needy classification.
*	OH	*A	/83 (+)	Ohio has added Ribicoff children.
*	OK	*A	4/83 (+)	Oklahoma expanded Medicaid coverage to help those pregnant women who would be eligible for coverage after the birth of their babies to receive better total obstetrical care.
	OR	*A	12/82 (+)	The Oregon legislature expanded the definition of the categorically needy to include persons required for inclusion under federal law and persons who may be included optionally subject to availability of federal funds (SB 889).

RI \*P /83 (-) Rhode Island has submitted an 1115 waiver in order to establish a distinct group of medically needy individuals whose incomes are at or below \$1,500 and who are in need of ICF care. ICF services would be provided only to this group of medically needy. An earlier attempt to implement this policy through a state plan amendment was disapproved by HCFA.

RI \*A 5/82 (+) (H 7312) The Rhode Island legislature enacted a law to require that self-pay nursing home residents be permitted to remain in the nursing homes as a Medicaid recipient after depleting their funds if they have paid privately for at least six months.

RI \*A 4/82 (-) Rhode Island reduced the eligible age of a child to 18 (including foster children) unless the child is completing secondary school or training before his/her 19th birthday. This is in line with an effort to conform Medicaid to AFDC eligibility standards.

RI \*A 4/82 ( ) Rhode Island established work expense deductions for categorically/medically needy families in accordance with those established for the AFDC program.

RI \*A 4/82 (+) Rhode Island began providing medical coverage for eligible pregnant women within the first five months of pregnancy after confirmation of pregnancy is made.

RI \*A 4/82 (-) Rhode Island began deeming the resources and income from sponsors of aliens to aliens in determining the aliens' eligibility for Medical Assistance.

SC \*A 1/82 (-) South Carolina eliminated Medicaid coverage for the General Disability Assistance and General Assistance-Ineligible Spouse groups. (These groups were previously covered through state funds only).

\* TX \*A /83 (+) The Texas legislature has enacted a law which would add coverage of prenatal care for pregnant women if and when the federal government makes additional funds available for this purpose.

\* TX \*P /83 (+) (HB 1616) A bill has been introduced into the Texas legislature which would provide for Medicaid coverage for children of unemployed parents.



- \* TX \*P /83 (+) (HB 1649) A bill has been introduced into the Texas legislature which would cover individuals under 21 and pregnant women who are medically needy for pregnancy-related services, emergency room services, and a number of other services but excluding inpatient hospital and long term care services.
- VA \*A 7/82 (-) Virginia discontinued coverage of medically and categorically needy ADC recipients between the ages of 18 and 21 years.
- VA \*A 7/82 (-) Virginia discontinued coverage of recipients whose Medicaid eligibility was based upon Title XX child care payments.
- VA \*A 7/82 (-) Virginia discontinued coverage of medically needy caretaker relatives whose eligibility was based upon ADC (exceptions: prenatal and delivery services for pregnant women).
- \* WY \*A /82 (-) Wyoming dropped coverage for 18- to 21-year old AFDC recipients. (Wyoming law states that Medicaid will cover only those individuals whom federal law requires to be covered. Thus, the passage of the Omnibus Budget Reconciliation Act in 1981 by the U.S. Congress mandated the elimination of this group in Wyoming.)

#### B. Income Levels

- \* AL \*A 7/82 (-) Alabama raised the monthly income eligibility level for persons in nursing homes. Rather than setting it at a dollar amount, as they have in the past, they set it at 300 percent of the SSI. Currently that amount is \$852.90.
- AK \*A 2/82 (+) The State of Alaska increased the personal needs allowance for institutionalized individuals from \$35 to \$70 per month.
- \* CA \*A 1/84 (+) (AB 1593) The California legislature allowed a long term care facility resident who would be ineligible for Medi-Cal due to excess income, to be eligible if specified conditions pertaining to employment within the facility are met.
- \* CA \*A 7/83 (+) The California legislature enacted AB 223 (a budget trailer bill) which raised the maintenance need standards to \$459 for one person, \$567 for a household of two where one



member is a child, \$709 for a three-person household, and \$834 for a household of four. A different, higher standard of \$709 was set for two-person households in which both individuals are adults. (The figure for a one-person family was arrived at by multiplying 80 percent of the AFDC payment level for two by 133-1/3 percent. The figure for a two-adult household was calculated by multiplying the AFDC payment level for three by 133-1/3 percent. All other two-person families' standards are reached by multiplying the AFDC payment level for two by 133-1/3 percent.) California has submitted to HCFA a state plan amendment.

- \* CA \*A 2/83 (+) As a result of the passage of TEFRA, which requires a single maintenance needs standard for all medically needy groups, and of related litigation (Minor vs. Myers), the maintenance needs standards were set at 133-1/3% of the AFDC cash grant level for a family of corresponding size.
- CA \*A 9/82 (-) California reduced the "maintenance need" standards (the amount of income allowed before a person is required to pay for some part of his health care prior to receiving a Medi-Cal card) from 115 percent of the AFDC cash grant level to the lowest level that will continue to qualify for federal financial participation.
- CA \*A 7/82 (-) California has eliminated an "income shelter" for aged, blind, or disabled persons whose income is above Supplemental Security Income/State Supplemental Payment cash grant levels due to employment or retirement income. Income deductions ranged from a maximum of \$130 per month for a single aged person to a maximum of \$483 per month for a blind couple. Elimination of these income disregards means that these beneficiaries are required to spend down this "excess income" on their health care needs to the new maintenance need standard before they are eligible to receive a Medi-Cal card.
- CT \*X 2/82 (+) The Connecticut legislature reported a bill to increase income eligibility levels to the federal maximum allowed (H5442). This proposal was dropped.
- \* DC \*A 3/83 (+) The District of Columbia revised its medically needy income levels.

\* FL \*A 7/82 (+) Florida increased the cost of care from \$297 to \$319 for Level Two cases (Level One cases were increased from \$286 to \$307) for aged, blind and disabled recipients in adult foster homes. (Level Two cases need assistance in performing the basic activities of daily living; Level One cases are more self-sufficient.) It also increased levels for individuals receiving room and board with personal care from \$312 to \$335. Personal needs allowance for both groups is \$38. (Contact: Bill Brattain 904/487-2380)

\* FL \*A 7/82 (+) Florida increased the income limitations from \$720 to \$786 per month for individuals in nursing homes, mental hospitals, TB hospitals, and ICFs/MR. [Contact Bill Brattain 904/487-2380]

\* GA \*A 7/83 (+) Georgia increased AFDC payment levels. Contact for Georgia eligibility issues: Ollie Faulk 404/656-4347.

\* GA \*A 7/82 (+) Georgia increased the personal needs allowance for members of AFDC families (children and adults) from \$10.00 to \$13.00.

\* KS \*A 5/83 (-) Kansas reduced income and resource eligibility levels for the medically needy to the levels of the SSI program.

KS \*X 5/83 (-) Kansas considered a proposal to decrease the AFDC medically needy protected income levels to the cash standards. However, this proposal was dropped, due to changes in federal regulations eliminating this possibility.

LA \*A 7/82 (-) Louisiana increased the maximum allowable monthly income limit for long term care resident from \$794.10 to \$852.90. For a couple occupying the same room in a long term care facility, the double rate of \$1,708.50 would apply.

LA \*A 4/82 (+) Louisiana increased from \$25 to \$50 per month the personal care needs allowance for aged, blind, and disabled recipients residing in Intermediate Care Facilities I and II, Intermediate Care Facilities for the Mentally Retarded and Skilled Nursing Facilities.

ME \*A 7/82 (+) Maine increased AFDC and medically needy income levels.

MD \*A 7/82 (+) Maryland increased the AFDC payment levels by 9%.

	MA	*C	/83 (-)	Massachusetts is considering the use of the institutional standard (personal needs allowance of \$40 per month) for cases on administratively necessary days in acute hospitals.
*	NV	*A	/82 (-)	Nevada capped its income standards for persons residing in Title XIX medical institutions at \$714 per month.
	NH	*A	7/82 (+)	New Hampshire increased from \$237 to \$308 the amount of money that is exempted monthly for institutionalized individuals to provide maintenance of a non-institutionalized spouse. The amount set aside for each additional dependent is also increased from \$237 to \$308.
*	NH	*A	2/82 (+)	New Hampshire raised the income scale for AFDC-related recipients.
*	NJ	*A	7/82 (+)	New Jersey increased the income eligibility standard for nursing home residents to \$852.90 per month.
	NM	*A	7/82 (+)	New Mexico increased the income eligibility level from \$725 to \$778 per month for nursing home residents.
	NM	*X	/82 (-)	New Mexico submitted a waiver request which would allow it to cease granting cost-of-living increases. However, the request was denied.
*	NY	*A	1/84 (+)	New York raised the income eligibility level for the medically needy.
*	NY	*A	1/84 (+)	New York raised the amounts of liquid resource exemptions for the medically needy.
*	NY	*A	7/83 (+)	New York raised the income eligibility level for the medically needy.
*	NY	*A	7/83 (+)	New York raised the amounts of liquid resource exemptions for the medically needy.
*	NY	*A	11/82 (+)	New York began excluding burial trusts or other funds separately identifiable for burial expenses up to \$1,500 each for individual, spouse or any immediate family member.
	NY	*A	7/82 (+)	New York raised the income eligibility level for the medically needy.



*	NC	*A	/83 (+)	(SB 7) The North Carolina legislature enacted legislation which eliminates parents income for determining the eligibility of a child who had been hospitalized for at least 180 days.
	NC	*A	8/82 (+)	North Carolina AFDC payment levels were increased by 5%. Medically needy income levels were increased to 133 1/3% of the new AFDC payment level.
*	PA	*A	7/83 (+)	Pennsylvania raised medically needy income eligibility levels only for those individuals living alone.
*	PA	*A	7/82 (+)	Pennsylvania raised medically needy recipients' income eligibility levels.
*	PA	*A	5/82 (+)	Pennsylvania added 18- to 21-year-old AFDC recipients regardless of whether or not they are attending school.
*	PA	*A	/82 (+)	Pennsylvania added, under the authority of the State Adoption Opportunities Act, those receiving adoption assistance or foster care who also meet AFDC requirements.
	RI	*X	4/82 (-)	Rhode Island proposed reduction of the income limits for the medically needy to the levels that were in effect prior to July 1, 1981. At the time of this proposal, they were \$4600 for an individual and \$5100 for a family of two; these would be reduced to \$4400 and \$4900, respectively. However, this proposal was dropped.
	RI	*A	4/82 (-)	Rhode Island adjusted the categorically needy resource limits to match those of the AFDC program (\$1,000 per assistance unit) and revised their transfer of assets policy.
*	SC	*A	/83 (+)	South Carolina raised the maximum allowable income level for institutionalized individuals from \$852.90 to \$912.90.
	SC	*A	/82 (+)	South Carolina raised the maximum allowable income level for institutionalized individuals from \$714 to \$852.90.
	TN	*A	7/82 (-)	For individuals in long term medical care facilities, Tennessee set the income level of 300% of the current SSI Federal Benefit Rate.



*	TN	*A	7/82 (+)	<p>Tennessee raised its income cap for the institutionalized categorically needy to 300% of the SSI payment. It also opted to cover as categorically needy the unborn children of intact families meeting the AFDC income and resources standards.</p> <p>At the same time, Tennessee reduced its medically needy eligible population to only pregnant mothers and children under 21 in special groupings. These include children under psychiatric care; children receiving child care in child-placing institutions, both public and private; and children with special diagnoses, such as renal disease or hemophilia. It should be noted that, as a 209(b) state utilizing eligibility criteria more restrictive than SSI, Tennessee must allow otherwise eligible aged, blind and disabled individuals to spend down excess income and become categorically eligible for benefits.</p>
*	VT	*A	/83 (+)	Vermont raised income eligibility standards for both categorically and medically needy individuals to adjust for cost-of-living increases.
*	VT	*A	/82 (+)	Vermont raised income eligibility standards for both categorically and medically needy individuals to adjust for cost-of-living increases.
*	VT	*A	/81 (+)	Vermont raised income eligibility standards for both categorically and medically needy individuals to adjust for cost-of-living increases.
	VA	*A	/82 (-)	Virginia lowered its income eligibility level for aged, blind, and disabled individuals in mental hospitals and ICFs/MR from 300% of the SSI income standard to \$852.90 per month.
	VA	*A	/82 ( )	(HB 627) The Virginia legislature enacted a law which amends the state's transfer of assets restrictions.
*	WA	*A	7/83 (+)	The state of Washington increased income eligibility levels for the medically needy, concurrent with increased grant standards.
*	WA	*A	7/83 (+)	The state of Washington increased the personal needs allowance from \$35.50 to \$34.50 for institutionalized individuals.
*	WA	*A	7/82 (+)	The state of Washington increased income eligibility levels for the medically needy, concurrent with increased grant standards.

- \* WI \*A /83 (-) (SB 83) The Wisconsin legislature passed a law which reduces the personal needs allowance from \$45 per month to \$42.50 in 1983-84 and to \$40 per month in 1984-85.

### C. Resource Standards/Rules

- \* AL \*A 7/82 (-) Alabama modified its transfer of assets policy. When an applicant for Medicaid, within 24 months of applying, transfers assets in excess of Agency standards for less than fair market value in order to qualify for or maintain eligibility, he or she shall be barred from eligibility until they meet eligibility criteria as determined by the Medicaid Agency.
- CA \*A 11/82 (-) The net market value of real property not being used as a home that may be owned by a Medi-Cal beneficiary has been reduced from \$25,000 to \$6,000. The law provides that in the event the beneficiary's principal residence becomes other property subject to the \$6,000 limit, the beneficiary shall remain eligible provided that the property is listed for sale at its fair market value established by a licensed real estate appraiser. Furthermore, the law provides that to the extent permitted by federal regulations, the state shall place a lien on the property for the cost of health services provided to the beneficiary. This provision will have a significant impact on persons in long-term care who are not expected to return home since under current regulations the patient's home, unless it is occupied by a spouse or minor child, is considered "other real property."
- CA \*A 9/82 (-) The California legislature eliminated law provisions which permitted retroactive spenddown of property by Medi-Cal applicants whose property exceeded the property limits in any of the three months prior to their month of application. Previously, non-cash grant applicants received retroactive Medi-Cal eligibility for up to three months prior to the month of application if they did not have "other property" (savings, stocks, bonds, insurance policies, etc.) in excess of 200 percent of the normally allowed property limits. However, as a condition of eligibility, such persons would have to "spend-down" to normal property limits. Under the provisions of

the new law, persons with property in excess of normal limits will not be eligible for Medi-Cal.

- |   |    |    |           |   |
|---|----|----|-----------|---|
|   | CT | *X | 7/82 (+)  | The Connecticut legislature reported the introduction of a bill to increase asset levels from \$850 to \$1,500 for Medicaid eligibility purposes (H5230). This proposal was dropped.  |
| * | GA | *A | 7/83 (+)  | Georgia increased the home maintenance level for non-institutionalized spouses to the SSI level of \$324.30.  |
| * | HI | *A | 11/83 (+) | Hawaii eliminated home property as a resource, regardless of its value. Previously, there was a \$40,000 limit on home property. (If an applicant's home was valued at over \$40,000, he/she was ineligible to receive Medical Assistance.)   |
|   | HI | *A | 7/82 (-)  | Hawaii adopted a disposal of assets provision which stipulates that if assets valued at more than \$1,200 are disposed of at less than fair market value within 24 months of application for Medical Assistance, the applicant will be rendered ineligible for a period of two years.               |
|   | HI | *A | 7/82 (-)  | Hawaii adopted a provision deeming aliens' sponsors' income and assets as available to the alien requesting assistance.   |
|   | HI | *A | /82 (-)   | (HR 298) The Hawaii legislature passed a resolution which requested a study of the feasibility of changing eligibility requirements to allow the elderly to retain their homes. The resultant report was submitted to the legislature, recommending the elimination of home property as a resource. |
|   | IN | *A | 7/82 (+)  | Indiana increased the ceiling on the value of insurance policies not regarded as a resource from a face value of \$1,000 to \$1,400.  |
|   | IA | *A | 4/82 (-)  | Iowa implemented a transfer of assets prohibition. If a transfer is made within two years of application for Medicaid at less than fair market value, eligibility is postponed for up to six years on a sliding scale depending upon the amount of the transfer.                                    |
| * | KS | *A | 5/83 (-)  | Kansas reduced income and resource eligibility levels for the medically needy to the levels of the SSI program.   |



- KS \*X 5/83 (-) Kansas considered a proposal to adopt the cash resource standards of \$500 for one person or \$1,000 for two or more persons for the AFDC medically needy coverage group. However, this proposal was dropped, due to changes in federal regulations eliminating this possibility.
- \* MA \*A /83 (-) (S 2232) The Massachusetts legislature enacted legislation which establishes a one month spend-down policy for the following persons: 1) disabled individuals who are independent living program participants and can avoid institutionalization through personal care services; 2) individuals in long-term care institutions; 3) individuals who have difficulty meeting six-month spenddown requirements, but each month incur predictable and consistently high medical expenses through the use of one program or service; and, 4) individuals at risk of institutionalization, but capable of remaining in the community. The Act also requires the Department to apply for necessary federal waivers.
- MA \*X /83 (-) Massachusetts investigated the possibility of establishing a resource spend-down policy through the provisions of the Omnibus Reconciliation Act. This is no longer being considered.
- MA \*A 12/82 (-) (SB 2137) The Massachusetts legislature enacted a law to tighten the state's transfer of assets limitations.
- \* MI \*A 7/83 (-) (HB 4558) Michigan's Appropriations Act contains a provision that sets transfer of assets requirements.
- \* MN \*A 6/83 (-) (SF 1234) The Minnesota legislature enacted a law which requires the spouse of a Medicaid recipient to contribute one-third of excess resources to cost of care, exempting Medicaid exclusions and \$10,000 of nonexcluded resources.
- \* MN \*A 6/83 (+) (SF 1234) The Minnesota legislature enacted a law which increased the maximum limit on cash and liquid assets from \$2,000 to \$3,000 per individual and \$4,000 to \$6,000 per two person household. The law also provides that cash and liquid may include insurance policies having a cash surrender value and a prepaid funeral contract.



- \* MN \*A 6/83 (+) (SF 1234) The Minnesota legislature enacted a law which allowed institutionalized recipient to transfer liquid assets to noninstitutionalized spouse under certain conditions including: 1) spouse is not receiving or applying for medical assistance; 2) spouse has less than \$10,000 in liquid assets; 3) total amount transferred plus spouses assets cannot be more than \$10,000; and, 4) transfer can take place only at time of application for medical assistance.
  
- NV \*A 3/82 (-) Nevada implemented a policy that, if an individual applies for Medicaid within 24 months of transferring assets with the uncompensated value of \$1,500 or more at less than full market value, he will be rendered ineligible for Medical Assistance for two years.
  
- NY \*A /82 (-) New York tightened its transfer of assets restrictions by making ineligible for 24 months those individuals transferring less than \$12,000 in assets at less than fair market value within two years of applying for Medicaid; and, for those transferring assets of more than \$12,000, rendering them ineligible for 24 months plus one month for each \$2,000 over \$12,000. This policy resulted from the passage of S. 7838 by the state legislature.
  
- NY \*A 7/82 (+) New York raised the amounts of liquid resource exemptions for the medically needy.
  
- \* NC \*P /83 (-) (H 460) The North Carolina legislature reports the introduction of legislation which establishes a Medicaid transfer of assets prohibition at below fair market value.
  
- OK \*A 1/82 (-) Oklahoma lowered the allowable equity in an automobile for AFDC families from \$4,500 to \$1,500, in order to comply with federal requirements.
  
- RI \*A /83 (-) (SB 2072) The Rhode Island legislature enacted a bill which imposes liens on the estates of recipients over 65 who are not survived by a spouse, a child under 21, or a blind or disabled child.
  
- \* RI \*C /83 (-) Rhode Island is considering the restriction of transfers of assets.

- TN \*A 7/82 (-) (SB 2143) The Tennessee legislature enacted a law which tightened its transfer of assets limitations.
- \* UT \*P /83 (-) (SB 16) The Utah legislature reports introduction of a bill to require that income of parents or spouse of institutionalized recipients be deemed.
- \* WA \*A 7/83 (+) The state of Washington reduced, from \$1,500 to \$500, the deductible for acute and emergent medical services per family per twelve-month period for its medically needy and medically indigent recipients, who are covered under the Limited Casualty Program (LCP).
- WV \*P 2/83 (-) The West Virginia legislature is considering a bill to tighten its transfer of asset restrictions.
- WI \*A /82 (+) Wisconsin changed its policy regarding the consideration of motor vehicles when determining Medicaid eligibility for AFDC-related medically needy. In the past, for both the categorically and medically needy, the applicant's vehicle with the highest equity was disregarded, and if there was a second vehicle it was considered a resource. The new policy states that if proof is shown that the vehicle with the highest equity is not used for employment or medical purposes, and a second vehicle is used for these purposes, then neither will be counted as a resource.

#### D. Eligibility Definitions

- CA \*A 1/82 (-) A recently passed California law brings the state into compliance with federal AFDC regulations and restricts eligibility of aliens (AB2-X).
- \* CO \*A 6/83 (+) (SB 130) The Colorado legislature enacted a law which increased from \$1,000 to \$1,500 the amount of a prepaid funeral expense contract excluded from eligibility determination.
- \* CO \*A 11/82 (-) Colorado adopted a new transfer of assets policy. An applicant for Medicaid who disposes of countable assets at less than fair market value within two years of his Medicaid application will be presumed to have made the transfer in order to receive Medical Assistance and will be penalized.

- \* HI \*P /83 ( ) Hawaii is considering a proposal to cease using its own criteria for determining aged, blind and disabled individuals, eligibility, under Section 209(b), and to adopt federal determination of eligibility for this group (with SSI criteria) through the Section 1634 option.
  
- \* LA \*A 4/83 (-) Louisiana adopted a new policy that persons who are eligible for Medicaid under a special income level of less than 300 percent of the SSI standard payment amount won't be covered for a partial calendar month of long term care institutionalization. Exceptions will be made if: (a) the person's eligibility has been established prior to admittance to the nursing home; or (b) if the person is transferred directly from a hospital to a nursing home.
  
- \* LA \*P /83 ( ) Louisiana proposes to conform its transfer of assets policy to federal regulations.
  
- LA \*A 10/82 (+) Louisiana excluded deeming of income and resources in certain cases where applicants utilize home- and community-based services in lieu of institutional care.
  
- LA \*A 8/82 (+) Louisiana changed its policy to exclude burial plots and prepaid burial contracts as a resource.
  
- LA \*A 4/82 (-) Louisiana reduced period of eligibility of Refugees and Cuban/Haitian Entrants certified for cash and medical assistance from 24 to 18 months from the date of entry into the United States.
  
- MI \*A 12/82 ( ) Michigan had implemented a policy that the child is not deprived of parental care or support based on absence of a parent, if the absent parent is away from home solely because he/she is in the armed services.
  
- MI \*P 1/82 (-) The Michigan State legislature has introduced a bill which requires that a person must have resided in the state for at least six months in the last 12 months to be eligible for general assistance (HB 5160).



- \* MN \*A 6/83 (-) (SF 1234) The Minnesota legislature enacted a law which amended restriction on transfer of assets policy. Uner this provision the number of months that a person is ineligible due to any uncompensated transfer of assets is computed by dividing the amount transferred by the statewide average SNF per diem.
  
- \* MN \*A 6/83 (+) (SF 1234) The Minnesota legislature enacted a law which excluded homesteads from transfer of assets restrictions if one of the following is applicable: the patient is expected to return to the homestead; the homestead title was transferred to patient's spouse, child under 21, or child who is blind or disabled; patient can show intention to dispose of home at fair market value; or denial of eligibility would pose a threat to the patient's health and well-being.
  
- \* MN \*P /83 (-) (HF 1114) The Minnesota legislature reports introduction of a bill to tighten transfer of assets restrictions.
  
- \* NE \*C /83 (-) Nebraska is considering the elimination of the medically needy program.
  
- \* NE \*P /83 (-) (LB 113) The Nebraska legislature is considering a bill to tighten transfer of assets restrictions.
  
- \* OR \*A 1/84 (+) (H 2805) The Oregon legislature passed a law to provide Medicaid coverage to certain categories of medically needy individuals. The individuals identified in the act are pregnant women who would be elibible for AFC including such aid based on the unemployment of a parent, whether or not the woman is eligible for cash assistance and persons who would be eligible for AFDC based upon the unemployment of a parent, whether or not the state provides cash assistance.
  
- \* OR \*C /83 (-) Oregon is conducting a study to assess the feasibility and desirability of adding coverage of home care for disabled children. It is also deliberating on the appropriate approach to such a change; whether it should be through a waiver or a state plan amendment.



- \* OR \*C /83 (-) Oregon is conducting a study to assess the feasibility and desirability of adding coverage of home care for disabled children. It is also deliberating on the appropriate approach to such a change; whether it should be through a waiver or a state plan amendment.
- \* OR \*X /83 ( ) Oregon proposed to eliminate the AFDC two-adult standard. However, this proposal was dropped.
- \* OR \*X /83 (+) (HB 2805) The Oregon legislature considered legislation to re-establish an AFDC-UP program. However, this proposal was dropped.
- \* TN \*A 7/82 (+) Tennessee raised its income cap for the institutionalized categorically needy to 300% of the SSI payment. It also opted to cover as categorically needy the unborn children of intact families meeting the AFDC income and resources standards.

At the same time, Tennessee reduced its medically needy eligible population to only pregnant mothers and children under 21 in special groupings. These include children under psychiatric care; children receiving child care in child-placing institutions, both public and private; and children with special diagnoses, such as renal disease or hemophilia. It should be noted that, as a 209(b) state utilizing eligibility criteria more restrictive than SSI, Tennessee must allow otherwise eligible aged, blind and disabled individuals to spend down excess income and become categorically eligible for benefits.

- \* TN \*A 7/82 (-) Tennessee reduced its medically needy eligibility population to only pregnant mothers and children under 21 in special groupings. These include children under psychiatric care; children receiving child care in child-placing institutions, both public and private; and children with special diagnoses, such as renal disease or hemophilia. It should be noted that, as a 209(b) state utilizing eligibility criteria more restrictive than SSI, Tennessee must allow otherwise eligible aged, blind and disabled individuals to spend down excess income and become categorically eligible for benefits. At the same time, Tennessee raised its income cap for the institutionalized

categorically needy to 300 percent of the SSI payment. It also opted to cover as categorically needy the unborn children of intact families meeting the AFDC income and resources standards.

- \* WA \*A /83 (+) The state of Washington reinstated coverage of two-parent families under the AFDC-E program.

#### E. Other Eligibility Changes

- CA \*A 9/82 (-) The California legislature eliminated provisions that permitted Medically Indigent Adult (MIA) eligibles to be determined "retroactively" eligible for any month up to three months prior to their application for Medi-Cal. The law provides an exception for MIAs residing in skilled nursing or intermediate care facilities and for pregnant women. This provision has, in the past, provided financial relief to persons with major health care costs who, if they had known of the existence of the Medi-Cal program and had applied for benefits, would have been determined eligible. Elimination of this benefit means that any medical expenses incurred before the month in which a person applies for Medi-Cal will be borne solely by that person unless there is private insurance coverage.
- \* IL \*X /83 (+) From March 1983 through June 30, 1983, Illinois eliminated coverage of non-pregnant adults under the AFDC Medically Needy program. However, this coverage was restored July 1, 1983 after legislative passage of a tax package.
- \* IL \*X /83 (+) Illinois eliminated coverage of medically indigent medical care recipients from March through June 1983, due to budgetary limitations. Coverage was restored with legislative passage of the tax package.
- NE \*A 7/82 (-) Nebraska adopted, for their ADC-related medically needy, a retrospective budgeting methodology for determining financial eligibility for Medicaid services. The previous system was prospective; income was projected for a six-month period.
- NY \*A 8/82 (+) New York terminated its 209(b) status and began, once again, to use the less restrictive 1634 eligibility criteria under the SSI program for its aged, blind and disabled recipients.

#### IV. ALTERNATIVE SERVICE DELIVERY/PROGRAM MANAGEMENT

##### A. Capitation for Acute Care Services

CA \*A 9/83 (-) The Santa Barbara Health Initiative became effective September 1983. This project is one of a limited number which are being funded with HCFA research and demonstration grants in six states for the purpose of studying their impact on competition among insurers and providers of health care. It is one of two such projects in California: The other is the Monterey Health Initiative.

Under the Santa Barbara Health Initiative, a primary care, case management network has been established to serve persons residing within Santa Barbara County who are eligible for Medi-Cal. The Santa Barbara County Special Health Authority has assumed financial responsibility to arrange for the full scope of benefits, with a few exceptions (such as dental benefits, EPSDT services and Short/Doyle mental health services--regular mental health services are included), to these individuals.

The Authority will receive a prospective amount of 95 percent of fee-for-service charges. The Authority will reimburse providers also at 95 percent of fee-for-service charges, on a prospective basis. Personal physicians chosen by beneficiaries will serve as case managers, making referrals when necessary.

\* CA \*A 8/83 ( ) (AB 1167) The California legislature enacted a law which provided that contracts negotiated for inpatient hospital services entered into after January 1, 1984 and all contracts for services other than inpatient hospital be open to inspection one year after they are fully executed.

CA \*A 7/83 (-) In addition to the Special Hospital Negotiator's/Commission's contract authority, recent California legislation authorizes the Director of the Department of Health Services to contract with noninstitutional providers under a wide variety of arrangements, to enter into "case management" contracts with primary care providers, and to purchase drug products and medical supplies on a volume basis.



a. Noninstitutional Provider Contracts

The law authorizes the Director to contract with a variety of non-institutional providers of health care services under a variety of financial and organizational configurations. Overall, such contracts are intended to achieve a more efficient and cost-effective provision of services. The Director is also empowered to require providers to enter into capitated contracts as a condition of participation in the Medi-Cal program in order to prevent or correct irregular/abusive billing practices. The provisions became operative when the California Medical Assistance Commission assumed its full responsibilities (July 1, 1983).

b. Primary Care Case Management

The law provides for a "primary care case management" approach to the provision of Medi-Cal benefits. The Department or counties are authorized to enter into case management contracts within defined geographic areas. Beneficiaries in such areas will be required to select a primary case manager as a condition of eligibility for Medi-Cal benefits. Beneficiaries are permitted to disenroll for "good cause" as established by the Department. Maximum reimbursement under case management contracts cannot exceed 100 percent of the fee-for-service projections for the same benefit package.

\* CA \*A 6/83 (-)

The Monterey Health Initiative became effective June 1, 1983. This project is one of a limited number which are being funded with HCFA research and demonstration grants in six states for the purpose of studying their impact on competition among insurers and providers of health care.

Under the Initiative, a primary care, case management network has been established to serve persons residing within Monterey County who are eligible for Medi-Cal. The Monterey County Special Health Authority has assumed financial responsibility to arrange for the full scope of benefits, with a few exceptions (such as dental benefits, EPSDT services and Short/Doyle mental health services--regular mental health services are included), to these individuals.



The Authority will receive a prospective amount of 95 percent of fee-for-service charges, and will be at risk to provide services. The Authority will reimburse providers 95 percent of fee-for-service charges, retrospectively. Personal physicians chosen by beneficiaries will serve as case managers, making referrals when necessary. A case management fee will be used as an incentive to encourage physician participation in the program.

- \* CA \*A /83 (-) California received a Sec. 2175 waiver of freedom-of-choice and statewideness requirements in order to establish a Primary Care Case Management program for cash grant Medicaid eligibles in four areas of the state. Recipients will be invited to participate on a voluntary basis. Contracts will be awarded to physicians, clinics or other providers for provision of primary care to participating recipients. Physician services will be reimbursed on a capitated basis, and contractors can elect to receive capitated rates for certain other services, such as lab/x-ray services, vision care and pharmacy services. Other non-capitated services will be reimbursed on a fee-for-service basis.
- CA \*A /83 (-) The State of California implemented a voluntary quality assurance program for the state's prepaid health plans. The design of this program is based on the results of the state PHRED project, an 1115 waiver project which recently was completed.
- \* CA \*A /83 ( ) (SB 312) the California legislature exempted children's hospitals and charitable research hospitals from the negotiated contract requirements for FY83-84.
- \* CA \*A /83 (-) (SB 739) The California legislature redefined the appeals procedures for hospitals with Medi-Cal contracts negotiated by the Czar and alters the definition of an emergency for the purpose of reimbursing hospitals not under negotiated contracts for emergency services.
- \* CA \*A /83 ( ) (SB 746) The California legislature required the development of reimbursement methods and utilization controls for hospitals having Medi-Cal contracts.

The California legislature provided for the creation of a special hospital negotiator in the Governor's Office. Effective July 1, 1983, the negotiator became the Executive Director of the California Medical Assistance Commission.

The law empowers the special hospital negotiator (and later, the commission) to negotiate contracts with a variety of providers, organized delivery systems, and private insurance carriers for institutional and noninstitutional services to program beneficiaries.

a. The special hospital negotiator is authorized to negotiate the rates, terms and conditions of contracts with acute care hospitals for the provision of inpatient services to Medi-Cal beneficiaries. The negotiator must consider the following factors in negotiating contracts or drawing specifications for competitive bidding:

- Beneficiary access.
- Utilization controls.
- Ability to render services efficiently and economically.
- Demonstrated ability to provide or arrange needed specialized services.
- Protection against fraud and abuse.
- Other factors which would reduce costs, promote access, or enhance the quality of care.
- Capacity to provide a given tertiary service on a regional basis.
- Recognition of the variations in severity of illness and complexity of care.

The following types of hospitals are exempt from the contracting program and will continue to be eligible to participate in the Medi-Cal program without entering into contracts:

- Out-of-state hospitals.
- HMOs and other organized health systems.
- State hospitals.
- Children's hospitals and charitable research hospitals as defined in Section 10178 of the California Insurance Code for FY 1982-83

The following types of beneficiaries are exempt from the contracting program and will be able to obtain care at any inpatient facility in the state:

- Beneficiaries in life-threatening emergency situations or situations that could result in permanent impairment.
- Beneficiaries who live or reside farther than the community travel time standard from a contract hospital, as defined by the Department, if the hospital providing services is closer than a contract hospital.
- Beneficiaries who are also eligible for hospital services under the Medicare program Part A.

All current utilization controls will remain in effect.

#### b. County Contracts

The law authorizes the special negotiator to negotiate exclusive contracts with counties for the provision of Medi-Cal benefits. Counties entering into such contracts may provide services directly or through subcontracts with institutional/noninstitutional providers and organized health systems or plans. Counties entering into contracts with the State are exempt from state Knox-Keene requirements. This part of the proposal has been withdrawn by the state.

#### c. Expanded Choice

California law requires the special negotiator, with assistance from the Public Employee's Retirement System Board, to submit a Request for Proposal (RFP) to potential contractors, including HMOs, PHPs, IPAs, insurance companies, and university medical care systems. At the request of a county or consortium of counties, the negotiator is required to develop a similar RFP specifically designed to meet the needs of that county or group of counties. The RFP will solicit bids from these entities to provide care to Medi-Cal beneficiaries through a capitated, pre-paid rate. The benefit package, as a minimum, must include all federally mandated benefits and may also include optional benefits authorized under state law. Public hearings are required prior to entering into contracts, and the negotiator is required to have negotiated with at least two other competitive health care plans in the county where a contract is proposed. Enrollment in



such a health care system is not mandatory, but once enrolled, the beneficiary must continue to be enrolled for at least six months. County employees are also eligible to enroll in such plans.

The law requires the special negotiator to establish pilot projects in at least two geographic areas to test the feasibility and cost effectiveness of this provision. Beneficiaries must have a choice of at least two health care systems through which to receive their care. Reimbursement for such pilots cannot exceed fee-for-service projections for the same service package in the same geographic area. The California Medical Assistance Commission is required to evaluate the cost effectiveness of such pilots by July 1, 1983. Projects may be terminated or expanded on the basis of the Commission report.

CA \*A /82 (-)

The law provides incentives for the expansion of Medi-Cal Prepaid Health Plans (PHPs) at the discretion of the Department. Specifically, the law: (1) provides a floor of 85 percent of fee-for-service projections as a minimum basis for PHP reimbursement, and for increased reimbursement for plans receiving below 90 percent; (2) guarantees capitation for enrollees for 6 months, regardless of changes in eligibility status; and (3) allows provision of benefits not currently covered by Medi-Cal as long as this does not result in a plan becoming more costly than the fee-for-service system.

CO \*A 2/83 (-)

Colorado received approval of a Sec. 2175 waiver to implement the Primary Care Physician Case Management Program. This project is being phased in on a statewide basis. Each recipient in the project areas will choose a primary care physician who will serve as his or her case manager, making referrals when necessary. Under this program Medicaid will not pay for non-emergency services provided in an emergency room setting, though emergency rooms will normally be reimbursed for the provision of an examination of the recipient to determine if an emergency exists. To date this program has resulted in an increase in physicians enrolled in the Colorado Medicaid Program.



To encourage physicians to participate in Medicaid and the Primary Care Physician Case Management Program, an incentive pool has been appropriated by the legislature. How it is to be distributed shall be decided by the Medicaid Single State Agency in collaboration with physician advisory groups.

- \*    CO    \*A       /83 (-)    The Colorado legislature has appropriated an incentive pool to encourage physicians to participate in Medicaid and the Primary Care Physician Case Management Program. How it is to be distributed will be decided by the Medicaid Single State Agency in collaboration with physician advisory groups.
- \*    CO    \*C       /83 (-)    Colorado is considering the provision of primary care and other services on a non-HMO prepaid capitation basis. Possible approaches include state-defined HMOs, prepaid health plans, and health insuring organizations.
- CO    \*A       3/82 (-)    Colorado applied for a Sec. 2175 freedom of choice waiver to require Medicaid recipients in Mesa County to obtain health care services from providers associated with the Rocky Mountain Health Maintenance Organization. A two-year waiver was granted by HCFA on March 3, 1982. This initiative was subsequently replaced with another HCFA-approved statewide waiver for a "Primary Care Physician Case Management Program".
- \*    CT    \*C       1/84 (-)    In Connecticut, the Health Systems agency, in conjunction with the Medicaid agency, is considering applying for demonstration money to conduct a primary care case management study in Hartford, using an organization to coordinate the delivery of services by individual practitioners. Reimbursement would be on a capitated basis.
- \*    CT    \*A       10/83 (-)    (SHB 5590) The Connecticut legislature passed legislation allowing the Commissioner of Income Maintenance to contract with comprehensive health care providers (e.g., HMOs) on a prepaid capitated basis. The Act requires the Commissioner to allow Medicaid recipients to receive care under these contracts if costs to the state are lower than under the current system.

- CT \*A 6/83 (-) Connecticut began implementation of an HMO contract, and service delivery began June 1, 1983. A second HMO contract was implemented October 1, 1983.
- CT \*P /83 (-) In Connecticut, legislation is being proposed which would mandate that the Department conduct a pilot physicians case management project under federal waiver. The project would be targetted to a small area: Middletown. Reimbursement would be on a fee-for-services basis. It is hoped that the project can be implemented in the spring of 1984.
- \* FL \*A 7/83 (-) (SB 29XX) The Florida legislature enacted a law which authorized the Department to contract with providers and insurers on a prepaid per capita or aggregate fixed-sum basis for a comprehensive range of services to Medicaid recipients.
- \* FL \*A 1/83 (-) Florida is one of six states that received a three-year HCFA research and demonstration grant for a project testing various types of competitive health care delivery systems. The Florida program is designed to demonstrate a number of methods of promoting competition among health care providers and insurers. Among the models being tested: competitive alternative health plans, recipient case management, an alternative health plan for the frail elderly, and medical care vouchers.
- \* GA \*P /83 (-) Georgia has applied for a Sec. 2175 waiver in order to establish a case management system for providing dental services to children under 21 referred under the EPSDT program. Georgia initially would implement this program in one rural and one urban county. Results would be evaluated and, if it appeared to be effective, it would become a statewide program. Within the specified areas, yet to be selected, affected recipients would be given a choice of remaining with the dentist they previously had been visiting or of being assigned to the provider group(s) selected by the agency. In any case, they would receive all dental care from the selected case manager. Reimbursement would be on a capitation basis, with case managers receiving a flat fee per month.

- \* HI \*A 1/84 (-) Hawaii is expanding its HMO coverage. It is contracting with Health Plan Hawaii for provision of services, beginning January 1984. A contract with an additional HMO is pending. Prior to these, Hawaii has had only one HMO contract.
- \* HI \*A 4/83 (-) (SB 1290) The Hawaii legislature enacted a law to establish a demonstration project in which six-month HMO membership is guaranteed to voluntary AFDC enrollees.
- \* IL \*A 2/84 (-) Illinois is proposing to implement prepaid capitation programs for: dental services only; hospital inpatient services only; ambulatory services only; and full services, i.e., all services except dental and optometric. It is estimated that 10 percent of the state's medical care recipients will eventually participate. Forty thousand AFDC recipients are currently enrolled in an HMO.
- \* IN \*A /83 (-) Indiana is implementing a pilot program of HMO contracts for AFDC recipients.
- \* IA \*P /83 (-) Iowa is proposing to contract with an HMO.
- KS \*A 2/84 (-) Kansas has received a Sec. 2175 waiver and is planning to implement, in February 1984, a program establishing at least ten primary care networks within three counties in the state. The program will be open to all recipients except for Medicare-eligibles and individuals under foster care.
- \* KY \*A 1/84 (-) Kentucky received a Sec. 2175 freedom of choice waiver to provide inpatient acute care hospital services through a preferred provider arrangement to individuals in Fayette County.
- \* KY \*A 6/83 (-) Kentucky received a Sec. 2175 waiver to establish the "Citicare" case management program, which requires designated recipients to select a primary care provider responsible for providing primary care services and authorizing other necessary medical services. Providers/case managers are reimbursed on a capitated basis. The state will share cost savings with participating recipients through provision of additional services. This two-year mandatory program will cover all AFDC and AFDC-related recipients in Louisville and Jefferson Counties for physician services, lab and x-ray, emergency services, hospital inpatient, home



health and prescription drugs. Kentucky's goals in establishing Citicare are to:

- provide quality medical services to Medicaid clients;
- improve access to primary and preventive care while decreasing unnecessary emergency room and inpatient utilization;
- better control escalation of medical costs through a new system of care based on capitation;
- provide continuity of care and 24-hour coverage by participating primary care physicians selected by the client.

Citicare was originally scheduled to begin in November 1982, but the start-up date was changed to June 1983.

- \* KY \*P /83 (-) Kentucky has applied for a Sec. 2175 freedom of choice waiver to implement a preferred provider arrangement that will restrict providers from whom individuals can obtain inpatient acute care hospital services in certain counties.
- \* ME \*A 1/84 (-) Maine signed a contract with an HMO, the Franklin Area Health Plan, to cover the full range of Medicaid services for AFDC recipients in the West Central Maine area. Incentives for joining the HMO include an exemption from the drug copayment, and coverage of eyeglasses for all HMO members (Maine Medicaid ordinarily covers eyeglasses only for individuals under 21 and for individuals recovering from cataract surgery).
- MA \*A 7/83 (-) Massachusetts has received waivers (an 1115 statewideness waiver in April 1983 and a 2175 waiver in October 1982) in order to continue, expand and modify its case management system, developed under a 1979 federal grant. Interested providers will contract with the state to participate. Under the system, recipients are offered the option of obtaining their primary health care from participating providers (e.g., HMO, clinic, neighborhood health center) which are carefully prescreened for quality of services and financial accountability. Once recipients enroll with their chosen health care provider, they select the primary physician who will perform the case

management function. All primary care is received from that provider, and any additional care, including labs, X-rays, specialist consultations, and inpatient hospital care is monitored and arranged through the case manager. The revised program incorporates an ambulatory care capitation system with a fee-for-service, at-risk hospital fee reimbursement system. Any savings realized on hospital care will be shared with the provider. Contact: Jan Singer 617/727-8080.

MI \*A 4/83 (+) In cooperation with the Michigan Department of Mental Health, the Department of Social Services has received approval of two Sec. 2175 waivers to provide clinic-based mental health services; one to provide day treatment, and the other to expand outpatient care. The waivers allow reimbursement for services of non-physician personnel on a fee-for-service basis. Coverage is limited to services provided by Community Mental Health Services Boards throughout the state who are providing case management of the mental health services for the patients, who include both the mentally ill and the mentally retarded. This statewide project is known as the Primary Mental Health Clinic Sponsor Program, or the Clinic Services Program.

\* MI \*X /83 (-) (H 4821) The Michigan legislature introduced a bill which would require exclusive contracts on a competitive bid basis for inpatient hospital services. Under the provisions of this bill the state will be divided into districts and hospitals will be classified into categories, such as general, prenatal, and intensive care. Contracts will be awarded to the lowest bid in each district for the separate classes of hospital. Those hospitals receiving contracts cannot charge more than 115 percent of the Medicaid rate to non-Medicaid patients receiving similar services. This bill did not pass.

MI \*A 10/82 (-) Michigan applied for a Sec. 2175 freedom of choice waiver to allow the state to "lock-in" a Medicaid recipient to an HMO for a 6-month period after his first month of enrollment. The waiver was approved for a two-year period, effective January 1982. However, since this project was inextricably tied to the Primary Care Physician Sponsor Program, implementation was postponed until October 1982.

MI \*A 10/82 (-) Michigan received a Sec. 2175 freedom of choice waiver to establish a Primary Care Physician Sponsor Program to be pilot-tested in Wayne County and later statewide. A Medicaid recipient selects a participating physician sponsor who provides primary care and who authorizes any other necessary non-emergency medical services. Physician sponsors receive the usual fee for service plus a case management fee for each recipient. The waiver was approved by HCFA on February 9, 1982 for a two-year period. This program was implemented July 1, 1982; but a temporary restraining order was issued July 7, 1982. The order was lifted in October 1982 and the program began.

MI \*A 7/82 (-) The State of Michigan implemented a pilot primary care physician sponsor project in Wayne County. Most recipients are required to either enroll in a health maintenance organization or designate a physician sponsor to act as case manager. Participating physicians are paid on a fee-for-service basis, plus a monthly per-recipient case-management fee.

MI \*A 1/82 (-) Michigan received a Sec. 2175 freedom of choice waiver to implement a Capitated Ambulatory Program. Clinics or groups of physicians offering primary care and comprehensive health services will be reimbursed on a capitation risk basis. The provider agrees to arrange or deliver all ambulatory services and controls admissions to inpatient hospital (and perhaps LTC facilities) for recipients volunteering to participate in the program and shares in savings generated from such controls. This waiver was approved April 22, 1982. A statewideness waiver was approved August 25, 1982. During the first year of the waiver (April 1982 to April 1983) it was necessary to make changes in the automated payment system. HCFA has approved a one-year extension of the program, which will extend it to April 1985. The program is being phased in and began with five projects.

\* MN \*A 6/83 (-) (SF 1234) The Minnesota legislature enacted a law which authorized a demonstration project using prospective per capita payment and restrictions on recipient freedom of choice. Hospitals participating in the demonstration are exempt from the new inpatient hospital prospective system.



MN \*A /83 (-) Minnesota received a competitive health care system grant from HCFA to implement a demonstration project. It is presently in the planning stage and operation will begin in July, 1984 in three counties, one rural, one suburban, and one in the metropolitan Minneapolis-St. Paul area. In the three counties, the categorically needy Medicaid population will receive coverage on a pre-paid basis only, and may enroll with HMOs, private insurers or primary care clinics.

MN \*P 2/82 (-) (SF 2044) The Minnesota legislature reports that a bill has been introduced to establish a primary care case management system.

\* MO \*A 1/83 (-) Missouri implemented a prepaid health care program for Kansas City General Relief recipients.

MO \*A 7/82 (-) Missouri received a renewable four-year grant to establish a competitive health care system demonstration project. (Missouri is one of six states receiving such a grant). Effective July 1982, the project is in the planning stage at present. It initially involves 5,000 AFDC recipients in the Kansas City area (Jackson County) beginning in Autumn 1983. The program will then be expanded to the entire AFDC population of 28,000 in Jackson County, and eventually elsewhere in the state. The participants will be given a choice of two components: (1) prepaid health plans; or (b) individual physician sponsor (case manager) programs in which physicians have contracted with the state to provide services.

\* MO \*A 1/82 (-) Missouri implemented a prepaid health care program for St. Louis City general relief recipients.

NV \*A 11/83 (-) Nevada has received a Sec. 2175 waiver to establish a primary care network by contract with a university medical school. It will operate in two locations: a free-standing clinic in Reno and a hospital outpatient department in Las Vegas. Reimbursement will be on a monthly capitated basis for three services: physician, laboratory/x-ray and pharmacy services. The program will be voluntary. Recipients may dis-

enroll within 30 days of enrollment, but after 30 days they will be locked into the program unless they supply an adequate reason for dropping out.

- \* NV \*P /83 (-) Nevada has requested a Sec. 2175 freedom of choice waiver to implement a single source pharmacy project.
- NH \*A 1/83 (-) New Hampshire was granted a Sec. 2175 waiver to establish a case-management system in its Nashua District. Recipients, with certain specified exceptions, will be required to obtain health care through the Matthew Thornton HMO.
- NJ \*A 7/83 (-) New Jersey is participating in the "Medicaid Competition Demonstration Project" to encourage physicians to provide primary care to Medicaid patients and discourage non-emergency use of outpatient hospital services. The four-year project, the "Medicaid Personal Physician Plan," will involve providing case management by a primary care provider, which can be an HMO, insurer, group practice or independent physician contracting with the state on a capitation basis. The program is voluntary, but certain incentives for enrollment are provided. Recipients who choose to participate are guaranteed enrollment for six months. They are also guaranteed exemption from any copayments which the state may subsequently impose on Medicaid services. The program began July 1983 in three rural counties, Warren, Morris and Sussex, and statewide operation is being phased in.
- NJ \*A 10/82 (-) New Jersey has entered into its first Medicaid-HMO contract. Those recipients who participate are guaranteed enrollment for six months.
- \* NY \*A 7/83 (+) In New York, legislation has been passed which permits the state to pick up the share of costs incurred by guaranteeing for six months the eligibility of recipients who have joined HMO's and capitation plans. In order to guarantee six-month eligibility for those joining federally-qualified HMOs, an optional state plan amendment has been filed with HCFA Region II. To enable the guarantee for non-federally-qualified HMOs and other capitation programs, an 1115 waiver is being sought.

- \* NY \*A /83 (-) New York State signed a capitation contract with Lutheran Medical Center to provide comprehensive services on a prepaid capitation basis for 3,000 ADC and SSI eligibles. Special State legislation was necessary to permit this demonstration since it is the first capitation contract with a facility other than an HMO.
- NY \*A /83 (-) New York received a HCFA grant for a competitive health care system project. The New York project, referred to as "Medi-Cap" was implemented in 1983. It operates in Monroe County and pays providers a prepaid capitated amount per recipient, using both federal and state funds. It contracts with HMOs and with other prepaid health plans associated with clinics and hospital outpatient facilities and practitioners.
- \* NY \*P /83 (-) New York is considering a proposal to apply for a waiver to develop a mandatory primary care case management program in East Harlem.
- NY \*A 5/82 (-) New York has received a Sec. 2175 freedom of choice waiver to require that new Medicaid enrollees in a federally-qualified or state-certified HMO not be permitted to disenroll without good cause during the five-month period following the first month of enrollment. Enrollees may disenroll for any reason during the first 30 days following the effective date of enrollment.
- \* NY \*P /82 (-) New York has requested a Sec. 2175 freedom of choice waiver to limit psychological services to organized mental health clinics.
- NC \*A 3/83 (-) North Carolina received approval for a Sec. 2175 waiver to allow the state to contract for Medicaid services on a prepaid basis. The target date for implementation is June 1983. This two-year project will cover AFDC-categorically needy recipients in Durham, Wake and Edgecombe Counties. The primary care physician will act as case manager under the program. He will provide primary care, make and pay for referrals to specialists, and approve, but not pay for, hospital stays. He will be paid a monthly capitation rate prospectively for all surgical and medical services provided by physicians,



and for lab and X-ray services. All other services will be paid for on a fee-for-service basis. Providers are responsible for ensuring access to 24-hour care. The waiver will not apply to emergency services.

- \* OH \*A /84 (-) Ohio has established a fund of \$10 million in FY 84 and \$15 million in FY 85 to encourage HMOs to enroll AFDC recipients.
- OH \*C /83 (-) Ohio is considering implementation of a capitated primary care network.
- OH \*C /82 (-) Ohio is considering expanded use of HMOs.
- \* OR \*A 7/83 (-) (HB 3013) The Oregon legislature enacted a law which established the Oregon Health Care Cost Containment System to contract for hospital and/or physician services on a prepaid capitation basis. The state also established an Evaluation Task Force to monitor the System.
- \* OR \*A 7/83 (-) (HB 3013) The Oregon legislature enacted a law which authorized establishment of demonstration projects to: limit scope of the system to selected geographic areas; allow health plans to offer benefit enhancements; limit recipient freedom-of-choice; allow primary providers access to utilization data from other providers; and, implement prospective reimbursement for hospitals.
- \* OR \*P 10/83 (-) Oregon is seeking approval of a waiver of Section 1915(b)(4) (a Sec. 2175 freedom of choice waiver) in order to operate a case management system in four state metropolitan statistical areas. This project would require that AFDC recipients in these areas choose between an HMO or a Provider Care Organization (PCO). A PCO is a group of individual practitioners who join together for the purpose of contracting with the state on a prepaid capitation basis. Savings realized would be shared with the PCOs. It is hoped that this project could begin in mid-1984.
- \* PA \*X /83 (-) Pennsylvania is proposing to contract with an HIO (health-insuring organization) for provision of health care services to a segment of the Medicaid population. This would be initiated as a pilot program in one geographic area. Reimbursement would be on a prepaid, capitation basis. This proposal was withdrawn by the state.

- \* PA \*P /83 (-) Pennsylvania is proposing to phase in over several years a shift of a large number of Medicaid recipients from the third party fee-for-service system to prepaid capitation arrangements. This initiative was recommended by the Governors' Health Care Cost Containment Task Force.
- PA \*A 6/82 (-) Pennsylvania received approval for a Sec. 2175 waiver to establish a Primary Care Capitated Program. Four primary care centers provide a full range of case Medicaid services, with the exception of long-term care, to state residents who previously have not had access to capitated plans.
- \* TN \*A 4/83 ( ) Tennessee received approval of a Sec. 2175 waiver in order to implement a two-year case management program which initially will serve AFDC and AFDC-related recipients in two centers, one urban and one rural, with a third large metropolitan center phased in during the first part of operation. The state will contract, on a shared-risk prepayment basis, with the Tennessee Primary Care Network (TPCN), which will function as a health-insuring organization. The state has been authorized to enter into a primary contract with TPCN on a noncompetitive, negotiated basis. The TPCN will enter into secondary contracts with the primary care providers, and be responsible for enrolling recipients into the prepayment plan. Secondary contracts will be procured on a competitive basis to the extent possible and appropriate. Recipients will select a primary care provider. The primary care provider will be responsible for providing primary care services and for locating, coordinating, and monitoring other necessary medical services. Non-emergency services not provided by the primary care provider (e.g., outpatient hospital services), must be authorized by the primary care provider. Access to emergency services, however, will not be restricted. Laboratory and x-ray services provided independent of a physician will be competitively contracted.
- TN \*A 4/83 (-) Tennessee received three Sec. 2175 waivers to implement three case management programs. The first is for a project in Maury County, in which all eligible recipients are assigned a case manager. The second and third waivers cover two clinics in the Memphis area. These

specified clinics will provide case management services to their Medicaid patients. In each of these projects, the primary care physicians render primary care and accept responsibility for the recipient's health care, guaranteeing 24-hour-a-day and 7-day-a-week access. The physician is reimbursed by the usual and customary charges for service, plus a case management fee for each recipient. Recipients' access to specialty care is improved since all referrals to specialists are made only by the primary care physician or contractor. The waiver does not apply to emergency services.

- \* UT \*A /83 (-) Utah received a Sec. 2175 freedom of choice waiver to implement a selective provider contracting program for hospital services.
- \* UT \*P /83 (-) Utah has applied for a Sec. 2175 freedom of choice waiver to create a prepaid health plan to provide comprehensive clinic services and day treatment services to developmentally disabled, mentally retarded, adult mentally ill, child mentally ill, frail elderly, adult handicapped, chronic substance abuse recipients.
- UT \*A 3/82 (-) Utah received a Sec. 2175 freedom of choice waiver in order to limit recipients to one of three alternatives for primary care: (1) HMO Utah, a prepaid non-certified health delivery system sponsored by BC/BS of Utah; (2) Family Health Program, a certified HMO delivery system reimbursed by a contractual prepaid arrangement; or (3) a primary care physician on a fee-for-service basis.
- \* WA \*P 7/83 (-) Washington has received a Sec. 2175 freedom of choice waiver to implement a prepaid capitation plan to pay for prescription drugs provided to recipients in certain long term care facilities.
- WA \*P /82 (-) The State of Washington has proposed to establish a capitation program with a medical service bureau whereby recipients would be required to designate a primary care physician at the point of eligibility.



- \* WI \*A 5/83 (-) Wisconsin received a Sec. 2175 freedom of choice waiver that requires recipients who are not HMO enrollees to select a primary care physician or network. If, after a reasonable opportunity, a recipient does not select an HMO or primary provider, the state will make the selection.
  
- \* WI \*A /83 (-) (SB 83) The Wisconsin legislature enacted legislation to increase AFDC Medicaid enrollment in HMOs. The statute provides that by the end of the 1983-85 biennium AFDC enrollment in HMOs will be 37 percent in Milwaukee County, 35 percent in Dane County (Madison), and 100 percent in Marshfield.
  
- \* WI \*A /83 (-) (SB 83) The Wisconsin legislature passed a law that requires AFDC recipients in Milwaukee County to receive services through a primary provider if they do not choose to enroll in an HMO.
  
- WI \*A 11/82 (-) Wisconsin has received a Sec. 2175 freedom of choice waiver to implement a Gatekeeper Prudent Buyer Plan to Mental Health Care. This allows the state's county mental health boards to act as case-managers and prudent purchasers of inpatient and outpatient mental hygiene services for mental health patients from 22 to 64 years of age, and to prior authorize all such services. Estimated annual cost savings: \$1 million.
  
- WI \*A 5/82 (-) Wisconsin received a Sec. 2175 waiver to encourage provider risk-sharing through a phased-in case management provision that offers at least one HMO or prepayment option to all Medicaid recipients in several areas of the state. Participating recipients will be exempt from copayments. The costs are expected to be at or below the current statewide average per capita expenditure and thus lower overall. All qualified providers will have an opportunity to compete. (Estimated annual savings: \$3.7 million.)
  
- \* WI \*A 11/82 (-) Wisconsin received approval for a Sec. 2175 waiver of 1902(a)(1) for a program to provide primary care, case management services to recipients in several areas of the state where there are no HMOs. This program has not been implemented.

## **B. Long Term Care Delivery**

- \* AL \*P /83 (-) Alabama is developing a proposal for a Sec. 2176 home- and community-based care waiver to provide services to elderly and disabled individuals who are at risk of institutionalization in a nursing home. The project would operate statewide.
- \* AL \*A 10/82 (-) Alabama has received a Sec. 2176 home- and community-based long term care waiver to provide, on a statewide basis, habilitation services within the community to the mentally retarded who meet the admission criteria for ICFs/MR.
- \* AK \*P /83 (-) Alaska has applied for a Sec. 2176 waiver to provide: adult residential care, adult foster care, home health nursing, home health aide services, personal care attendant services, homemaker services, respite care, adult day health, physical modifications to the home, specialized foster care, group home services, vocational skills training and in-home normalized living training to the mentally retarded; and adult residential care, adult foster care, home health nursing, home health aide services, personal care attendant services, homemaker services, respite care, adult day health and physical modifications to the home to the aged and disabled.
- \* CA \*A 7/83 (-) California received approval of a Section 2176 home- and community-based long term care waiver in order to provide services to the frail elderly who participate in the Multipurpose Senior Services Project. This program was previously authorized as a three-year 1115 demonstration project.
- \* CA \*A 7/83 (-) California has received approval of a Section 2176 home- and community-based long term care waiver in order to provide alternative services to recipients who are residents of acute care hospitals, but are in stable condition and in need of skilled nursing services. Recipients could qualify only if the cost of necessary equipment and care in the home was lower than the cost of comparable hospital care. It is anticipated that only a small number of individuals would participate in such a program.

- \* CA \*A /83 (-) (AB 1138) The California legislature authorized a pilot project to provide adult day health services in for-profit facilities and limited reimbursement to the rate paid to non-profit facilities.
  
- \* CA \*A 12/82 (-) California received approval of a Section 2176 home- and community-based long term care waiver to provide alternative services for the mentally disordered. The program, which has not yet been implemented, will be administered by the California Department of Mental Health.
  
- \* CA \*A 7/82 (-) California has received a Section 2176 home- and community-based long term care waiver to provide services to developmentally disabled persons released from state hospitals. The program is administered by the California Department of Developmental Services. Covered services include: respite care, personal support and habilitation services, homemaker and home health services, adult day training, transportation, and direct client support.
  
- CA \*A /82 ( ) (A.B. 2860) The California legislature enacted a law which authorized the state to create and delineate the responsibility of a new state Department of Aging and Long Term Care (LTC). Community long term care agencies would administer a program of health and social services at the local level, funded from the budgets of the Department of Health Services (Medi-Cal) and the Department of Social Services (Title XX). The law establishes an interim Office of Long Term Care under the direction of the Governor's office to prepare an action plan for the legislature. The provisions of the Act would not become effective until the legislature approves the action plan and appropriates funds in the 1984-85 budget and until federal waivers for Medi-Cal are obtained.
  
- \* CO \*A 8/83 (-) Colorado began implementing a two-year home- and community-based long term care project for institutionalized individuals with psychiatric diagnoses who are chronically, seriously, or critically in need of mental health services. This program is authorized through a Sec. 2176 waiver approved by HCFA. It includes the following features:



- The service delivery package includes basic Medicaid services, community mental health clinic services, residential care (exclusive of room and board), respite care, and non-medical transportation.
- There is no age constraint attached to this program. The only requirements are that individuals must: a) be Medicaid eligible; b) be chronically, seriously, or critically psychiatrically disabled; c) be certified as needing an ICF or SNF level of care via the PSRO process.
- There are cost containment and prudent buyer provisions structured into the program regulations.
- The Division of Mental Health reviews care plans to assure conformance with the cost containment provisions.
- The new mental health client assessment, consisting of level of functioning scale, is completed by a mental health clinician and indicates the degree or amount of dysfunction a client is experiencing in nine socially relevant domains.

CO \*A 2/83 (-)

Colorado implemented a two-year long term care project which focuses on home- and community-based alternatives to institutionalization. This project, mandated by state statute, involved approval by HCFA of a 2176 waiver. The groundwork for this program was laid several years ago with passage of S.B. 38, which created a Community Care/Institutional Diversion Program, adding certain benefits to the Medicaid program. The following features of the program are particularly noteworthy:

1. The service delivery package is comprehensive, and includes home health services, personal care, homemaker services, respite care, transportation, adult day care, and case management.
2. In contrast to programs covering only a limited target population, the Colorado program covers all elderly and handicapped adults, including the 300% group.

3. There are cost containment and prudent buyer provisions structured into the program regulations.
4. Case management agencies are used to assure conformance with the cost containment provisions.
5. A new functional assessment instrument which arrays recipients along a continuum of necessity for care was developed; this is also used for nursing home placement determinations.
6. The process for the functional assessment includes a request by the physician for service, a level of care review by the state PSRO which also includes a length of service authorization, the actual functional assessment by the case management agency, and a review for appropriateness and cost containment by state Medicaid personnel.

CT \*A 6/83 (-) Connecticut has received a Section 2176 home- and community-based long term care waiver in order to provide alternative long term care services to recipients who would otherwise require institutionalization in a SNF or ICF. The agency contracted with Connecticut Community Care, Inc. to administer the program in Fairfield County and provide coordination, assessment, and monitoring services. Recipients being discharged from hospitals in Fairfield County are evaluated to determine candidacy for alternative forms of care.

CT \*A /83 (-) Connecticut Medicaid has been working with the Connecticut Department of Mental Health in developing an 1115 demonstration project, cosponsored by HUD and HHS, to provide for congregate housing for the deinstitutionalized mentally ill. This project calls for Medicaid to pay for traditionally non-Medicaid services in order to facilitate the community placement of mentally ill patients currently in state hospitals. The projected cost per capita is much lower than the current state institutional cost. An 1115 waiver has been approved. Funding for housing costs will be provided by HUD and funding for staffing will be covered with Medicaid funds. Four sites will be involved, with a small number of recipients at each site.

\* CT \*P /83 (-) Connecticut has applied for a Section 2176 home- and community-based long term care waiver in order to participate, with the Public Assistance agency, in a program entitled "New Horizons". This program would provide a community living arrangement and community-based services for individuals who are presently residing in a chronic disease hospital.

\* CT \*P /83 (-) Connecticut has applied for a Section 2176 "Model waiver" to provide case management services.

DE \*A 7/83 (-) Delaware received a Sec. 2176 home- and community-based long term care waiver to provide, on a statewide basis, community-based services to the mentally retarded at risk of institutionalization.

DE \*X /83 (-) Delaware prepared an application for a Sec. 2176 "model waiver" in order to allow a small group of individuals in need of long term care to remain in their homes, receive alternative long term care services and still retain their eligibility. Without a waiver, deemed family income would prevent them from remaining eligible while outside an institution. This proposal has been dropped.

DC \*C 9/82 (-) The District of Columbia is considering applying for a Sec. 2176 waiver for a home- and community-based long term care project.

\* FL \*P /83 (-) Florida has applied for a Section 2176 "Model waiver" to provide case management, diagnosis and evaluation, developmental training, family placement, training and therapy, respite care and transportation to developmentally disabled individuals who would otherwise require ICF/MR services.

\* FL \*P /83 (-) Florida has applied for a Section 2176 "Model waiver" to provide case management, medical therapeutic, specialized homemaker/home management, and personal care services to blind, disabled and aged individuals who would otherwise require SNF or ICF care.

FL \*A 7/82 (-) Florida received a Sec. 2176 waiver to provide Medical Adult Day Health Care for SSI recipients over 18 years of age who are in danger of institutionalization or who are inappropriately placed in a long term care facility. (Contact: Virginia Sprouse 904/488-9228.)



- FL \*A 7/82 (-) Florida has received two section 2176 home- and community-based LTC service waivers to provide case management, adult day health, and respite care services to the mentally retarded, aged, and disabled beneficiaries; homemaker, personal care services, counseling, escort, health support services and placement services for adults to the aged and disabled; and developmental training services, diagnostic and evaluation services, family placement, training and therapy services and transportation to the mentally retarded. These are three-year projects which will operate statewide.
- GA \*A 1/83 (-) The Georgia legislature passed the Community Care Act, whose main focus is the coordination of all non-institutional services for the elderly, including Medicaid services. A preliminary plan will be submitted in January 1983, and implementation begins July 1985.
- \* HI \*A /83 (-) Hawaii received a Section 2176 home- and community-based long term care waiver in order to establish a "nursing home without walls." Cost of this care could not exceed 75 percent of the cost of institutional care.
- HI \*A /83 (-) Hawaii received approval of a section 2176 home- and community-based long term care services waiver to provide alternative services to frail and elderly individuals who have been residing in a local hospital on Oahu Island and have been on a waiting list for placement in a nursing home. Certain of these individuals are being placed instead in foster homes and are to receive community-based services.
- \* HI \*A 10/82 (-) Hawaii received a Section 2176 home- and community-based long term care waiver to provide case management, physician extender, adult day health, habilitation and respite care services to mentally retarded beneficiaries.
- \* ID \*A 10/83 (-) Idaho implemented a "Model Waiver" project upon the approval of a Section 2176 home- and community-based long term care waiver. This program provides a number of new alternative services, including case management, minor adaptations to the home and adult day care, for up to fifty blind and disabled individuals in two geographic regions of the state.

- IL \*A 7/83 (-) Illinois received approval of a 2176 home- and community-based long term care waiver to provide approximately 1,547 developmentally disabled persons with habilitation services, respite care and special services.
- IL \*A 7/83 (-) Illinois received a Section 2176 home- and community-based long term care waiver to provide to approximately 1,800 elderly and physically disabled persons: chore/housekeeping, homemaker services, meals, transportation, case management and elderly-adult day care.
- \* IL \*P /83 (-) Illinois has applied for a Sec. 2176 "Model Waiver" to provide case management, respite care, environmental modification; and private duty nursing, and special medical supplies, equipment and appliances to individuals under age 21 who have physical impairments.
- \* IN \*P /83 (-) The Indiana legislature enacted in April 1983 a law requiring the state's Department of Public Welfare to request, no later than July 1, 1983, a 2176 home- and community-based long term care waiver in order to provide services for the elderly on a demonstration basis. The request has been submitted, as well as statewideness and comparability waivers. If approved, the program will provide services for categorically eligible recipients 65 and older within a sixteen-county area. The Department is to submit a report on the project's progress to the General Assembly on September 1, 1984.
- IN \*A 7/82 ( ) (HB 1202) The Indiana legislature reports that a bill has been passed to require the Department of Public Welfare to request a waiver for the provision and reimbursement of respite care services under the Medicaid program. In addition, the state would develop a respite care program for developmentally disabled and mentally ill individuals who are not eligible for Medicaid.
- IA \*A 1/82 (-) Iowa has received a Section 2176 home- and community-based LTC service waiver to provide pre-admission assessment, comprehensive care planning and case management services to mentally retarded, aged and disabled individuals who would otherwise require institutional care. Initial implementation will involve Scott County.

IA	*A	/82 (-)	(SB 2305) The Iowa legislature enacted a law which allows tax deductions for care of the elderly and disabled persons in the home.	
KS	*A	7/82 (-)	Kansas a Section 2176 home- and community-based LTC services waiver to provide case management, homemaker services, personal care services, home health aide services, adult day health services, habilitation services, respite care and hospice care to elderly and disabled persons who would otherwise require institutional care. Additional services provided include: adult family homes, congregate living homes, wellness monitoring, night support, medical attendant care, medical alert and monitoring system.	
KS	*X	/82 (-)	Kansas has requested a section 2176 home- and community-based LTC service waiver to provide occupational, physical and speech therapy to individuals currently residing in adult care homes within five Kansas counties. The state subsequently withdrew this waiver request.	
KS	*X	/82 (-)	Kansas requested a section 2176 home- and community-based LTC services waiver to establish two levels of intermediate care within the State plan: One for those individuals who receive a great deal of nursing services, and one level for those individuals who do not require a high degree of nursing services. HCFA disapproved this request on March 18, 1982, stating that it did not fall within the purview of the legislation authorizing such waivers.	
*	KY	*A	1/84 (-)	Kentucky received a Section 2176 home- and community-based long term care services waiver to provide adult day health services through adult day health centers.
	KY	*A	7/83 (-)	Kentucky received approval of a Sec. 2176 home- and community-based long term care waiver to implement a project providing alternatives to institutionalization for aged and disabled recipients in the Bluegrass Area Development District.
	KY	*A	4/83 (-)	Kentucky received approval of a Sec. 2176 home- and community-based long term care waiver to implement a project providing alternatives to institutionalization for the mentally retarded. The project is entitled, "Alternative Intermediate Services for the Mentally Retarded



(AIS/MR)". Initially, it will operate in nine regions, but eventually will be expanded state-wide.

- KY \*A 4/82 (-) (H 674) The Kentucky legislature has enacted a law to provide those services needed to prevent unnecessary institutionalization and to apply for waivers where required.
- KY \*X 1/82 (-) (S 36) The Kentucky legislature reported that a bill had been introduced to create a fund to receive contributions to Medicaid. The bill also gives state income tax deductions to fund contributors and to those caring for the elderly in the home. This proposal was dropped.
- \* LA \*P /83 (-) Louisiana has applied for a Section 2176 home- and community-based long term care waiver to provide substitute family care, respite care, and supervised apartment care services to individuals who would otherwise require SNF for ICF services.
- \* LA \*P /83 (-) Louisiana has applied for a Section 2176 home- and community-based long term care waiver to individuals who would be eligible under 42CFR435.231 and who are now eligible under 42CFR435.232 (mentally retarded, physically handicapped, chronically mentally ill, or substance abuse individuals).
- \* LA \*P /83 (-) Louisiana has applied for a Section 2176 home- and community-based services waiver to provide in-home and personal care attendant services to individuals who would be eligible under 42CFR435.231 and who are now eligible under 42CFR435.232.
- \* LA \*P /83 (-) Louisiana has applied for a Section 2176 home- and community-based services waiver to provide case management services to individuals who would otherwise require SNF and ICF services.
- \* LA \*P /83 (-) Louisiana has applied for a Section 2176 home- and community-based services waiver to provide financial assistance and services to families for specific needs of a mentally retarded individual to remain at home or to return home.
- LA \*A 1/82 (-) Louisiana received a section 2176 home- and community-based long term care services waiver to provide homemaker, adult day health, and habilitative services to aged, disabled, and mentally retarded beneficiaries.

ME \*A 11/83 (-) Maine has received a Sec. 2176 home- and community-based long term care waiver to provide habilitations, case management, transportation and respite care services to the mentally retarded as an alternative to institutionalization. The program will cover 200 recipients in the first year, 300 in the second and 400 in the third year.

ME \*C /83 (-) Maine is actively considering the feasibility of applying for a 2176 home- and community-based long term care waiver to provide services to the elderly.

\* MD \*A 7/83 (-) Maryland received a Section 2176 home- and community-based services waiver to provide case management, residential habilitation, day care and transportation services to 669 MR/DD recipients presently residing in two ICFs/MR (Rosewood and Henryton State Residential Centers).

\* MD \*P /83 (-) Maryland has applied for a Section 2176 "Model Waiver" to provide private duty nursing, home visits by specialty physicians, case management and medical equipment and supplies to no more than 50 persons under age 18 who would be eligible for Medicaid if institutionalized.

MA \*A 2/84 (-) The State of Massachusetts is implementing within its Managed Health Program an initiative for the elderly which will provide incentives for home health agencies and other providers to manage the care of the frail elderly and disabled in the community and hence avoid nursing home placement. This is a demonstration project which will operate at nine sites. Only state funds will be used.

\* MA \*A 7/83 (-) The State of Massachusetts is implementing within its Managed Health Project an initiative for the elderly which will provide incentives for providers to enroll and manage the care of nursing home residents with physician extenders.

MA \*A /83 (-) Massachusetts has received approval of two Section 2176 home- and community-based long term care waiver requests to provide various specified alternative services to two groups of recipients: the elderly and disabled, and the blind.

- \* MA \*P /83 (-) Massachusetts has applied for a Section 2176 home- and community-based services waiver to provide emergency response system, homemaker, orientation and mobility, home residence adaptation, habilitation, case management, residential care, sign language skill, and family involvement services to the aged, blind and developmentally disabled young adults.
- \* MA \*P /83 (-) Massachusetts has applied for a Section 2176 home- and community-based services waiver to provide case management, personal care, adult day, residential, respite care, transportation and adaptive services to individuals requiring ICF/MR.
- \* MA \*P /83 (-) Massachusetts has applied for a Section 2176 home- and community-based services waiver to provide case management, homemaker, chore, social day care, and respite care services to elderly and disabled individuals.
- MA \*X 2/82 (+) (H 988) The Massachusetts legislature reported that a bill has been introduced to continue Medicaid coverage to disabled persons for homemaker services. This proposal has been dropped.
- \* MI \*A 5/83 (-) Michigan has received a Section 2176 "Model Waiver" to provide case management, personal care, private duty nursing, environmental modification, extended home health, psychosocial, and respite care services to medically needy blind or disabled individuals under age 21 who would otherwise require institutional care.
- MI \*X 10/82 (-) The State of Michigan considered filing a waiver under Section 2176 of PL 97-35 for community-based LTC. Various delivery models and reimbursement methodologies were considered. Research was undertaken with particular emphasis on cost and utilization controls. This proposal has been dropped.
- \* MN \*A 6/83 (-) (SF 1003) The Minnesota legislature enacted a law which authorized voluntary enrollment of Medicaid recipients in Social HMO demonstration project.
- MN \*A /83 (-) Minnesota received a waiver to participate in a demonstration to test the feasibility of the Social/Health Maintenance Organization (S/HMO) concept. Under this program, to be operated by



a senior care organization and largest HMO in Minneapolis, both acute and long-term care services will be provided to elderly Medicaid, Medicare, and private pay clients on a capitation reimbursement basis. The program will provide capitated services to Minneapolis area elderly who are in jeopardy of institutionalization.

- MN \*A 7/82 (-) Minnesota has been granted a section 2176 home- and community-based LTC service waiver to provide case management, homemaker, home health aide, personal care, adult day health, and respite care services to aged and disabled beneficiaries. This program is county-administered. Not all counties have begun implementation; however, eventually 96 percent of the Medicaid population will be covered.
- \* MS \*A /83 (-) Mississippi received a Sec. 2176 "model waiver" in order to provide case management services for up to 50 categorically needy blind or disabled children aged 18 or under.
- MS \*A 7/82 (-) The Mississippi legislature enacted a law requiring the state Medicaid Commission and other concerned state agencies to submit a report in January of 1983 outlining a plan for coordination of long-term health care services in the state.
- \* MO \*P /83 (-) Missouri has applied for a Section 2176 home- and community-based services waiver to provide case management, home health, homemaker/chore, medical equipment and supplies, medical transportation, comprehensive pharmacy, and respite care to categorically needy children.
- MO \*A 7/82 (-) Missouri received a Section 2176 home- and community-based long term care service waiver. It allows for provision of day care services at the Homer G. Phillips Day Care Center to Medicaid recipients in jeopardy of institutionalization. This facility is in St. Louis.
- MO \*A 7/82 (-) Missouri received a Section 2176 home- and community-based long term care service waiver to provide homemaker/chore, adult day treatment, respite care, and adult family home services to aged and disabled beneficiaries. The program operates in three areas: (1) four rural counties; (b) a small metropolitan area; and (c) Jackson County, which includes Kansas City.

- \* MT \*A /83 (-) Montana received approval of a Section 2176 home- and community-based long term care services waiver to provide case management, homemaker, personal care, adult day health, habilitation, respite care, medical alert and monitoring systems, meals on wheels/congregate meals, transportation services, environmental modifications/rental of adaptive equipment, physical therapy, occupational therapy, speech pathology and audiology services to aged and disabled and mentally retarded beneficiaries.
- \* MT \*A 2/82 (-) Montana received a Section 2176 home- and community-based services waiver to provide case management, adult day health, habilitation, respite care, nursing, and psychologist services, and physical, occupational, and speech therapy to mentally retarded beneficiaries. This waiver was terminated by the state on 11/1/83.
- NE \*X /82 (-) Nebraska applied for a Sec. 2176 home- and community-based long term care waiver for provision of alternative care services to the mentally retarded. The application was not approved by HCFA.
- \* NE \*P /83 (-) Nebraska has applied for a Section 2176 home- and community-based services waiver to provide multi-disciplinary pre-admission screening and assessment, case management, adult day health, chore, transportation, respite care, and living skills training services to persons qualified for SNF or ICF care in Lancaster County.
- \* NE \*P /83 (-) Nebraska has applied for a Section 2176 home- and community-based services waiver to provide habilitation services and to allow supportive intervention for mentally retarded recipients.
- NV \*A 4/83 (-) Nevada considered applying for a 2176 home- and community-based long term care waiver to provide adult day care services to the aged who are in jeopardy of institutionalization. However, the proposal was dropped.
- NV \*X 4/83 (-) Nevada considered applying for a waiver in order to provide case management and personal care to the severely physically handicapped in community residences. However, the proposal was dropped.

NV \*A 7/82 (-) Nevada received a Section 2176 home- and community-based services waiver to provide case management and habilitation services in community-based residences to mentally retarded beneficiaries.

\* NV \*P /82 (-) Nevada has applied for a Section 2176 home- and community-based services waiver to provide case management, home health, personal care, respite care, and nursing services, and physical and occupational therapy, speech pathology, self-help devices, equipment and supplies, and minor home modifications to disabled persons eligible for placement in a SNF or ICF.

\* NV \*A /82 (-) Nevada received a "Katie Beckett" waiver to allow a handicapped child to remain in his home and receive home health care without losing eligibility due to the deeming of his parents' income.

\* NH \*A 10/83 (-) New Hampshire received a 2176 home- and community-based long term care waiver to provide services to the mentally retarded and the developmentally disabled.

\* NH \*P /83 (-) New Hampshire has applied for a Section 2176 home- and community-based services waiver to provide options to ICF care to the elderly and the chronically ill.

\* NJ \*A 10/83 (-) New Jersey received a Section 2176 home- and community-based long term care waiver to provide community-based alternatives to institutional long term care to the aged and disabled. This program will be phased in. In the first year seven counties will participate, in the second year seven more will join the program and in the final year, all of New Jersey's twenty-one counties will participate.

\* NJ \*A 10/83 (-) New Jersey received a Section 2176 home- and community-based services waiver to provide case management, home health medical day care, respite care, transportation, homemaker, social day care, and adult day health services, pharmaceuticals, and respite care sundries to elderly individuals.

\* NJ \*A 9/83 (-) New Jersey has received a Section 2176 "Model Waiver" to provide case management services to no more than 50 optionally categorically need blind and disabled children and adults.



- \* NJ \*A 10/82 (-) New Jersey received a 2176 home- and community-based long term care waiver to provide the mentally retarded with community-based alternatives to institutional long term care. The three-year project covers 625 recipients in the first year, 1300 in the second year, and 2600 in the third. It will cover those entering "licensed community residences for the developmentally disabled, which include certain group homes and skilled development thomes licensed by the state.
- NJ \*A 5/82 (+) New Jersey is conducting a demonstration project to provide service reimbursement for former psychiatric hospital patients in U.S. Department of Housing and Urban Development-sponsored community housing.
- NJ \*P 2/82 ( ) (A 707) The New Jersey legislature reported the introduction of a bill to create a new State authority to assist in finding sources of capital for nursing homes that allocate at least 75% of their beds to Medicaid patients.
- NJ \*P 2/82 (+) (SCR 82 and S 1060) The New Jersey legislature reported the introduction of a resolution bill to study the feasibility of providing Medicaid eligibility to certain handicapped children.
- NJ \*A /82 (-) New Jersey has received "Katie Beckett" waivers of eligibility on an individual case basis to permit institutionalized handicapped eligible children to receive adequate home care at lower cost than institutional care when parents' income exceeds the eligibility standard by a certain amount.
- \* NM \*A 7/83 (-) New Mexico has submitted a 2176 home- and community-based long term care waiver application in order to provide four types of alternative long term care services to the aged, blind and disabled in five communities in the state.
- \* NM \*A 7/83 (-) New Mexico has received a Section 2176 home- and community-based services waiver to provide case management, habilitation, respite care, and ancillary services to developmentally disabled individuals.
- \* NY \*A 9/83 (-) New York has received an 1115 waiver, effective September 1, 1983 to August 31, 1984, to develop a prospective reimbursement methodology for long term care facilities which utilizes a case mix formula. It is to allow for adequate

reimbursement of individual facility needs based on characteristics of the clients in the facilities.

- \* NY \*A /83 (-) (S 6810) The New York legislature enacted legislation for a demonstration project to provide foster family care to the elderly and disabled.
- \* NY \*A /83 (-) (S 5268) The New York legislature enacted legislation to continue for two more years demonstration projects for residential and medical care placements.
- \* NY \*A 6/82 (-) The Rensselaer County Channeling Demonstration became operational on June 7, 1982. This project is one of 10 models established throughout the country as part of a federal initiative, designed to test innovative methods of providing community and home based alternatives to institutionalization. the project serves as a central intake point for screening and assessing individual needs, developing a plan of care and arranging for necessary services (it provides a wider range of services than normally covered by Medicaid). It addresses cost control with a project-wide fixed budget. the program was authorized by federal waivers and state legislation. On July 29, 1983 it reached its target caseload of 200 active clients. The channeling project's largest contract extends through September 29, 1984.
- NY \*A 12/82 (-) New York has received a Sec. 2176 home and community-based long term care services waiver in order to provide services to the aged and disabled through the Long Term Home Health Care Program. This provider-specific project represents coordinated efforts to provide non-institutional long term home care services to recipients throughout the state by various provider groups approved through the CON process.
- \* NY \*A 1/82 (-) The state of New York has participated with the federal government in an evaluation of the development and organization of a long term home health care program. Included are analytical studies on the comparative costs and

utilization experience of the program as well as quantitative findings on the changes in the patterns of long term care services used in the state. Reports will be completed in the near future.

- \* NC \*P 4/83 ( ) North Carolina requested a Sec. 2176 "Model Waiver" for children under age 18 who are institutionalized or at risk of institutionalization because of the policy of deeming parental income. Services include: case management, nursing, home health aide, speech, occupational and physical therapy, respite care, durable medical equipment, home mobility aids, adult day care and personal care.
- \* NC \*A 2/83 ( ) North Carolina received a Sec. 2176 home- and community-based long term care services program for the mentally retarded of all ages who otherwise would be placed in an ICF/MR. Program is scheduled for implementation July 1983. It will provide a number of services, including: case management, home-maker, home health aide, personal care, adult day health, habilitation, respite care, screening, home mobility aids and durable medical equipment.
- NC \*A 7/82 (-) North Carolina received a Sec. 2176 home- and community-based long-term care waiver. The project is a county-administered program which provides alternatives to institutionalization for the aged and for disabled individuals 18 and above in eight counties. Some of the services being provided are: case management, homemaker, home health aide services, adult day health, respite care, chore services, preparation and delivery of meals, skilled nursing services and home mobility aids.
- \* ND \*A 10/83 (-) North Dakota received a Section 2176 home- and community-based services waiver to provide case management homemaker, home health aide, personal care, adult day care, respite care, non-medical transportation, and chore services to elderly and disabled individuals.
- ND \*A 4/83 (-) North Dakota received a Sec. 2176 home- and community-based long term care waiver. It covers developmentally disabled and mentally retarded (DD/MR) recipients for payment of case management, homemaker, home health aide, personal care, adult day care, habilitation and respite care services.



- \* OH \*A 10/83 (-) Ohio received a Section 2176 "Model Waiver" to provide case management, home modifications and supplies, habilitation, personal care/homemaker, respite care, and transportation to individuals with an MR/DD level of care need.
- \* OH \*A 10/83 (-) Ohio received a Section 2176 "Model Waiver" to provide case management, personal care, respite care, transportation, home modifications and supplies, habilitation, and homemaker services to categorically needy children under age 18 who have moderate, severe, and profound mental retardation and/or physical handicaps.
- \* OH \*A 7/83 (-) Ohio received a Section 2176 "Model Waiver" to provide an air conditioner, cost of installation, strained baby food, strained fruit juice, canned formula, pager, parental transportation for hospital visits, transportation, and an in-home respite care worker for forty hours per month for one individual.
- \* OH \*P /83 (-) Ohio has applied for a 2176 home- and community-based long term care waiver which would allow pre-admission screening of patients who are leaving hospitals and seeking admission to nursing homes in order to identify candidates for alternative care. The program would operate as a demonstration at two or three sites.
- \* OH \*P /83 (+) Ohio submitted a state plan amendment in order to offer habilitative services to the mentally retarded under the coverage category of rehabilitative services. The amendment was disapproved by HCFA but is currently under appeal.
- OH \*A /82 ( ) Ohio is one of ten states participating in a three-year, federally-funded demonstration project to determine the cost-effectiveness of community-based long-term care for recipients who would otherwise be institutionalized. The project is administered by the state's Commission on Aging, and will be open to Medicaid, Medicare and certain other individuals in Cuyahoga County. Waivers were obtained in order to provide, under the project, services not ordinarily covered by Ohio Medicaid.

- \* OK \*P /83 (-) Oklahoma has applied for a Section 2176 home- and community-based services waiver to provide habilitation, specialized foster care, early childhood intervention, adult day care, respite care, regional professional assessment team, and case management services to mentally retarded individuals.
  
- \* OK \*P /83 (-) Oklahoma has applied for a Section 2176 home- and community-based services waiver to provide share homes, in-home attendant care, specialized foster care, adult day care, respite care, and case management to the aged and disabled.
  
- \* PA \*A 7/83 (-) Pennsylvania received a Section 2176 home- and community-based long term care waiver in order to provide case management, adult day health, habilitation, transportation, therapy services (which include physical, occupational, speech, visual and behavior therapy), and minor physical adaptations to the community living arrangement resident for mentally retarded discharged from Pennhurst, a state institution (ICF/MR) in the Philadelphia area.
  
- \* PA \*P /83 (-) Pennsylvania has applied for a Section 2176 home- and community-based services waiver to provide case management, adult day health, and habilitation services in community living arrangements and vocational rehabilitation facilities; and therapy (physical or occupational, speech, visual and behavioral) services and minor physical adaptations to community living arrangement residences in Buck County.
  
- \* PA \*P /83 (-) Pennsylvania has applied for a Section 2176 home- and community-based services waiver to provide case management, adult day health, and habilitation services in community living arrangements and vocational rehabilitation facilities; and therapy (physical or occupational, speech, visual and behavioral) services and minor physical adaptations to community living arrangement residences in Delaware County.
  
- \* PA \*P /83 (-) Pennsylvania has applied for a Section 2176 home- and community-based services waiver to provide adult day health and habilitation services in community living arrangements and vocational rehabilitation facilities; and transportation, therapy (behavioral, speech,

visual, physical, and occupational) services and minor adaptations to the community living arrangement residences in Chester County.

- \* PA \*P /83 (-) Pennsylvania has applied for a Section 2176 home- and community-based services waiver to provide adult day health and habilitation services in community living arrangements and vocational rehabilitation facilities; and transportation, therapy (behavioral, speech, visual, physical, and occupational) services and minor adaptations to the community living arrangement residences in Montgomery County.
- \* PA \*A 7/83 (-) Pennsylvania received a Section 2176 home- and community-based long term care waiver to provide alternative long term care to certain patients currently residing in a state-run ICF/MR in Allegheny County.
- \* PA \*P /83 (-) Pennsylvania is planning to submit a Section 2176 home- and community-based long term care waiver application in order to provide alternative care to the severely physically handicapped.
- \* PA \*C /83 (-) Pennsylvania is considering capitation of drug costs for nursing home recipients.
- \* RI \*A 7/83 (-) Rhode Island received a Section 2176 home- and community-based services waiver to provide case management, homemaker, adult habilitation, respite care, and, under certain conditions, early intervention, adult foster care, specialized homemaker services, and devices to adapt the home environment, minor assistance devices and transportation for mentally retarded recipients.
- \* RI \*A 4/83 (-) Rhode Island has received approval for a three-year Sec. 2176 home- and community-based services waiver in order to provide alternative community care for the chronically mentally ill. Under this program, certain patients will be released from a certain state facility and will be placed into group homes.
- RI \*A 1/82 (-) Rhode Island received a Section 2176 home- and community-based LTC waiver to provide alternatives to institutional care for the chronically impaired elderly (i.e., aged and disabled categorically needy individuals). This is a pilot project involving seven hospitals. Patients who qualify for a nursing home would be assessed



for the alternative program, which includes home health agency visits, durable medical equipment where appropriate, case management, day care and/or homemaker services. The cost of provision of these services could be no higher than the cost that nursing home care would be. (Contact: Lewis Treistman 401/464-3575.)

SC \*A 1/83 (-) South Carolina received a Sec. 2176 waiver to provide home- and community-based services to eligible Medicaid recipients. The waivers are to provide case management services to determine and provide the appropriate level of care for aged recipients and disabled recipients 18 and older who would otherwise require institutional care; and for "statewideness" and "amount, duration, and scope of services" requirements set forth in sections 1902 (a)(1) and 1902 (a)(10) of the Act, respectively.

This program was phased in and became statewide on August 1, 1983.

SC \*A 1/82 (-) South Carolina was chosen to participate in a demonstration legislated under Section 966 of Public Law 96-499 (the Omnibus Reconciliation Act of 1980) which allowed them to establish a Homemaker/Home Health Aide Project in four counties. The project is funded at 90 percent by HCFA and will last for 4 years, including 6-month start-up and close-out periods. The state agency is training and employing (through a subcontract) 25 AFDC recipients in each county to care for the elderly, handicapped and disabled so that they may remain in their homes and avoid institutionalization. The service is available without regard to income, and a reasonable amount is charged on a sliding scale basis for services provided to individuals who have income in excess of 200 percent of the state needs standards.

Waivers approved for this project are:

- Section 1902 (a)(1) - Statewideness 42 CFR 431.50
- Section 1902 (a)(10) - Amount, duration and scope of services. 42 CFR 440.240(b)
- Section 1902 (a)(17) - Continuation of Medicaid eligibility for at least 1 year for eligible participants employed under the project. 42 CFR 435.112.

SD \*A 6/82 (-) South Dakota has received a Section 2176 home- and community-based services waiver to provide the following services to developmentally disabled and mentally retarded beneficiaries: case management and habilitation services; dietary services; nursing services; psychological services; physicians' services; pharmacy and dental services; physical, occupational and speech therapy; audiological and optometric services; eyeglasses and transportation.

\* TN \*P /83 (-) Tennessee has applied for a Section 2176 home- and community-based services waiver to provide case management, personal care, home health, adult day care, respite care, transportation, medical equipment, home mobility aids and home-delivered meals to individuals requiring institutional care.

\* TN \*P /83 (-) Tennessee has applied for a Section 2176 home- and community services waiver to provide case management, personal care, respite care, nursing and therapy services, minor home modifications, durable medical equipment, home-delivered meals and transportation for eligible individuals in Shelby County.

TX \*A 1/83 (-) Texas has received a 2176 home- and community-based long-term care waiver to implement a small project in Amarillo offering alternative community-based care to hospital discharge patients who are aged and/or disabled. Services offered will include: case management, personal care, emergency response systems, home-delivered meals, minor home modifications, and rehabilitation services provided in the home (physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders).

UT \*A 9/82 (-) Utah was granted a Sec. 2176 waiver. The program operates on a case management and core service basis, with case managers assuring that each patient receives services based on his individual plan of care. Provided services include: home health care, homemaker services, personal care services, adult day health care, habilitation, respite care, hospice services, night support, medical alert and monitoring systems, and minor revisions to the home. The program is being phased in.

- VT \*A 4/82 (-) Vermont has received a Section 2176 home- and community-based long term care waiver to provide family education and training, respite care, service coordination, client support services, day activity, intensive day programs, adult day health care, case management and residentially-based habilitation and treatment services to mentally retarded and mentally ill beneficiaries.
- VA \*A 6/82 (-) Virginia has been granted a Sec. 2176 waiver to provide home- and community-based personal care services, on a statewide basis, to elderly and disabled individuals who might otherwise require nursing home care. The waiver also provides for long term care pre-admission screening of recipients.
- WA \*A 3/83 (-) Washington received a Sec. 2176 home- and community-based long term care services waiver (COPEs) to provide case management, personal care, congregate care, and licensed adult family home services for nursing home-eligible Medicaid recipients. The cost of services provided to the recipient cannot exceed 80 percent of the state's average Medicaid nursing home rate.
- \* WA \*A 10/83 (-) Washington received a Sec. 2176 home- and community-based long term care services waiver in order to provide alternative care for developmentally disabled clients.
- \* WV \*A 7/82 (-) West Virginia received a Sec. 2176 home- and community-based long term care waiver. The project provides habilitation and respite care to the mentally retarded; and case management, homemaker, home health aide, respite care, chore services, adult day care, adult family care and personal care home support services and skilled nursing services to the aged and disabled.
- \* WI \*A 10/83 (-) Wisconsin received a Section 2176 home- and community-based long term care waiver to implement the "Community Integration Program" which will provide counties with Medicaid funds for the provision of non-institutional long term care services to individuals relocated from three state-run Centers for the Developmentally Disabled (these are institutions at the ICF/MR level). This program is currently in the developmental stage. It will be phased in to eventually become statewide. Services include:



case management, habilitation, and respite care. (Note: this request was a companion to a Sec. 2175 application that was withdrawn by the state.)

\* WI \*A /83 (-) (SB 83) The Wisconsin legislature passed legislation to establish the Nursing Home Alternatives Pilot Program. The program permits up to five counties to receive state Medicaid funds equal to the amount that would have been spent for increased use of nursing homes. The funds can be used for community-based care or nursing home services, with the participating counties liable for the nonfederal share of costs of increasing nursing home utilization. Only those counties that have participated in the Community Options Program since January 1, 1983 are eligible to participate.

WI \*A 1/82 (-) Wisconsin initiated a new pilot program called the Community Options Program. This program will phase in a mandatory preadmission screening for all potential nursing home patients who are or are anticipated to become Medicaid eligible. Limited resources are being made available to counties to provide the services necessary to support the elderly in the community rather than institutionalizing them. The intent of the program is to reverse the trend of increasing nursing home utilization.

### C. Other Approaches

\* AZ \*A /83 (-) (SB 1341) The Arizona legislature enacted a law which establishes procedures for reinsuring high-cost medical cases.

\* AZ \*A /83 (-) Arizona adopted a policy to include private sector employees in RFPs for FY 84 contracts.

\* AR \*A /83 (-) (HB 817) The Arkansas legislature enacted a law which allows a tax credit of up to \$500 for care of a mentally retarded child at home.

CA \*A 7/83 (-) The California legislature mandated the development of pilot projects to test the feasibility and cost-effectiveness of consolidating administration of mental health services through the California Short-Doyle program. Under these arrangements psychology/psychiatric services would be

eliminated as Medi-Cal benefits and all patients would be directed to utilize Short-Doyle providers for mental health services. A federal waiver to implement this pilot is being pursued.

- \* CA \*A /83 (-) (AB 1734) The California legislature exempted from CON process those free-standing outpatient surgery units that only perform cataract surgery for Medi-Cal recipients. And, exempted hospitals from preexisting obligations to serve Medi-Cal if they serve members of an HMO that has negotiated to contract for Medi-Cal services but has not yet obtained a contract.
- CT \*P /83 (-) In conjunction with the Connecticut Alcohol and Drug Abuse Council, the Department of Income Maintenance proposed obtaining an 1115 waiver in order to provide, under the Medicaid program, alcoholism treatment services in a residential facility which is currently ineligible for Medicaid reimbursement. These services would be much less expensive than the current practice of reimbursing hospitals for inpatient and outpatient services for alcoholics. Currently Medicare is operating within this project and it is planned that Medicaid will begin to participate in the second year of the demonstration project. A final decision by the Medicaid agency is pending.
- \* DE \*A 7/83 (+) (HB 361) The Delaware legislature enacted a law which made a supplemental appropriation of \$12,359,600 for Medicaid services in state institutions and \$2,040,400 for Medicaid services in non-state institutions.
- \* FL \*A 6/83 (-) (HB 434) The Florida legislature enacted a law which provided that nursing homes without a certificate of need shall not receive a license. The Act also requires that, when deciding to issue a license, the Department consider the applicant's statement of intent designating a percentage beds to Medicaid, the percentage to be all or part of bed need as identified in the local plan.
- \* ME \*A 8/83 (-) Maine implemented a Demonstration Program for the Deinstitutionalization of the Chronically Mentally Ill, jointly sponsored by the federal Departments of Health and Human Services and Housing and Urban Development. This project is authorized by an 1115 waiver. Medicaid will

reimburse four designated community residential facilities for specified therapeutic and rehabilitative services to chronically mentally ill residents who qualify for the program.

- \* ME \*A 7/83 (-) (SB 608) The Maine legislature enacted a law which established a prospective, mandatory all-payor rate-setting system for reimbursing inpatient hospital services. The Act establishes a Health Care Finance Commission, appointed by the governor, to administer the program in consultation with three advisory committees composed of professional, hospital, and payor representatives. The Commission will seek a Medicare waiver. the Commission is responsible for establishing an apportioning revenue limits for each hospital by computing financial requirements minus available resources plus revenue deductions. Major third party payors pay by periodic interim payments, other purchasers pay on the basis of charges established by the hospital not to exceed the portion of the revenue limit allocated to this group. The Act also establishes the Management Support Fund to support improvement in management and information systems. The Fund is derived from revenues received by hospitals pursuant to a specific adjustment to financial requirements. Assets of the Fund will be used to assist small hospitals in developing the capabilities necessary to function under the new reimbursement system. Finally, the Act establishes a statewide limit on total annual capital and non-capital costs subject to CON approval. The limit is set at 1 percent of hospital financial requirements.
- \* MD \*C /83 (-) Maryland is considering a change in its policies in order to redirect utilization toward community-based ambulatory primary care. No decisions have yet been made as to what approach to take.
- \* MA \*A 9/83 (-) Massachusetts received a waiver authorizing a joint project with Medicare to provide case managed medical care for nursing home patients who are dual entitlees. The program covers nurse practitioner/physician teams who provide primary care, and are available on a 24-hour basis. The program began at one site and will eventually be expanded to eleven sites. There will be an evaluation of the program, and if it is found to be successful, Medicare may expand it to other states.



- \* MA \*P /83 (-) Massachusetts proposes to implement, in January 1984, a case management program for non-institutionalized elderly Medicaid recipients who also have Medicare coverage. They will be enrolled at nine primary care sites. A case management fee of \$3 per patient per month will be paid to providers as an incentive to participate. Although most of the savings realized from this program will accrue to Medicare (Medicaid pays the recipients' coinsurance and deductibles, and Medicare pays claims for provision of service), the goal is to encourage these recipients to find a health care system which can provide preventive care and will be available if they become ill. Providers will include health centers, physician group practices and outpatient departments. This program may eventually be expanded to cover the entire state. Note: This is solely a Medicaid project; Medicare is not participating.
- \* MA \*A /83 (-) (S 2179) The Massachusetts legislature enacted legislation to establish a statewide program to provide early intervention services. Early intervention services are provided to children between birth and three years of age, and their families, who have identified handicapping conditions or children who are at risk for developmental delays due to biological, established, or environmental factors. Services include speech, occupational, and physical therapy, social work, psychological, educational, and nursing services.
- MA \*X 2/82 ( ) (S 1329) The Massachusetts legislature reports that a bill has been introduced to provide a \$3000 tax exemption for care of the elderly at home. This proposal has been dropped.
- MI \*A 1/83 (-) Michigan has received a waiver to implement a limited hospice demonstration project at one location, using capitated per diem rates.
- MI \*A 7/82 (-) Michigan was selected to participate in a four-year Demonstration Project sponsored by the Health Care Financing Administration. The purpose of this project is to demonstrate the feasibility and effectiveness of providing alcoholism treatment services in freestanding alcoholism treatment facilities. Sixteen facilities were enrolled in three test site

areas. Services being provided by the facilities include detoxification, residential treatment, and outpatient counseling (depending on the licensure of the facility).

- \* MN \*A /83 (-) (HF 670, SF 695) The Minnesota legislature enacted a law establishing a moratorium on CON approval for nursing home beds (other than ICF/MRs). New Medicaid-certified beds may not be added; nursing homes may not change the level-of-care certification of existing beds; and no new nursing home licenses will be issued if this will cause increased Medicaid spending. (Exceptions may be granted when necessary to replace decertified beds, or for certain new facilities, or when facilities provide for special dietary needs, or if change in certification would result in lower Medicaid payment.)
- \* MN \*A 7/83 (-) Minnesota is modifying its nursing home program in several ways. It has moved to a prospective reimbursement system (see Reimbursement subsection), and is attempting to channel long term care patients into alternatives to institutionalization where appropriate. It has doubled its expenditures on alternative care and has implemented a number of demonstration projects. It has also established a moratorium on certification of additional nursing home beds (HF 670, SF 695), and has appointed an interagency board for quality assurance, to insure continued quality of care in nursing homes.
- \* MN \*P /83 (-) The Minnesota legislature considered a bill which would provide a tax credit for home care of the elderly who are eligible for Medicaid. The proposal was not adopted.
- MN \*P 2/82 (-) (HF 1861) The Minnesota legislature reported that a bill has been introduced to allow state tax credits for care of the elderly in the home.
- \* MO \*A 7/83 (-) (HB 825) The Missouri legislature enacted a law which established an 18 month moratorium on CON approvals for hospitals. The law provides that no CON shall be issued for additional hospital beds or for reallocating nursing home beds to hospital beds. CON may be issued for additional beds in an existing facility that is not located in an SMSA.

- \* MO \*A 7/83 (-) (HB 825) The Missouri legislature enacted a law which established a 4 year moratorium on CON approval for: SNFs and ICFs; hospital beds to be reallocated to nursing care; reallocations of beds to SNF or ICF from a hospital; and, reallocation of existing adult boarding, residential care, or ICF/MR facilities to ICF for SNF. Applications for CON for ICFs/MR are exempt from the moratorium.
- \* MO \*C /83 (-) Missouri is considering requesting a waiver for the St. Louis area which would allow children to obtain additional services at home in order to shorten hospital stays.
- MO \*P 1/82 (+) The Missouri legislature reported the introduction of a bill to provide hospice services.
- \* MT \*A /83 (-) (S 293) The Montana legislature authorized imposing conditions, such as limiting the number of Medicaid beds, on CON applications for long term care beds that would cause the long term care section of the Medicaid budget to be exceeded.
- \* NJ \*A /83 (+) (AB 1834) The New Jersey legislature enacted legislation to establish a demonstration project for the provision of respite care services to the elderly and disabled.
- \* NY \*A 1/83 (-) New York imposed a one-year moratorium, for Calendar Year 1983, on CON for hospital construction. The state will begin processing CON applications again in January 1984. (During 1983 the state executive and legislative branches held discussions on the feasibility of caps on hospital construction. No agreement has yet been reached.)
- \* NY \*A /83 (-) (A 6837) The New York legislature enacted legislation to establish a foster care for the elderly demonstration program.
- \* NY \*P /83 (-) New York state has proposed the imposition of caps on hospital construction. These would include an affordability cap (a state limit on how much construction will be approved) and a relative need cap, whereby facilities would be ranked according to relative needs. during



Calendar Year 1983, while discussions between the executive and legislative branches were undertaken, a moratorium on hospital construction was imposed. To date, no agreement has been reached on the proposal for legislation to impose caps.

- \* NY \*A /83 (-) (S 5560) The New York legislature passed a bill authorizing that AFDC recipients be trained and employed as homemakers and home health aides.
- \* NY \*A /83 ( ) (S 4873) The New York legislature passed a law that requires the Department to report on the respite care demonstration project.
- \* NY \*A 6/82 (-) The Rensselaer County Channeling Demonstration became operational on June 7, 1982. This project is one of 10 models established throughout the country as part of a federal initiative, designed to test innovative methods of providing community and home based alternatives to institutionalization. the project serves as a central intake point for screening and assessing individual needs, developing a plan of care and arranging for necessary services (it provides a wider range of services than normally covered by Medicaid). It addresses cost control with a project-wide fixed budget. the program was authorized by federal waivers and state legislation. On July 29, 1983 it reached its target caseload of 200 active clients. The channeling project's largest contract extends through September 29, 1984.
- \* NC \*A 6/83 (-) (HB 583) The North Carolina legislature enacted a law which imposes a one-year moratorium on construction of ICF/MR beds, beginning June 1983.
- \* OH \*A /83 (-) (S 269) The Ohio legislature enacted a law which placed a moratorium on CON applications for all types of health facilities, including urgent care centers, until July 1, 1984. Exeptions would be allowed for certain emergency situations and replacement beds.
- OR \*X 1/82 (-) The Oregon legislature reported that a bill was introduced to impose a one-year moratorium on nursing home bed expansion by denying CON in areas where the ratio of beds to elderly would exceed 40 per 1000. (SB975XX) However, this bill did not pass.

OR	*A	1/82 (-)	(HB 2485) The Oregon legislature enacted a law to provide state tax credits to care for the elderly at home.
*	PA	*P /83 (-)	(H 627) The Pennsylvania legislature is considering a bill to establish standards for nursing home bed needs.
	PA	*A 9/82 (-)	Pennsylvania has adopted regulations, as of September 1982, to stop paying nursing homes for depreciation and interest costs unless the institutions have received Certificate of Need (CON) prior to September 1982.
	PA	*A /82 (-)	Pennsylvania empaneled a Governor's Health Care Cost Containment Task Force. The Task Force's Final Report was issued in March 1983. Subsequently, the Medicaid agency began planning the implementation of four major recommendations:
			<ol style="list-style-type: none"> <li>1. a prospective hospital rate system based upon diagnosis-related groups (DRGs);</li> <li>2. enrollment of a large number of recipients into prepaid capitation programs;</li> <li>3. imposition of recipient copayments on all services allowed at the highest levels allowed by federal regulations; and</li> <li>4. volume purchase, through competitive bidding, of high volume goods and services.</li> </ol>
*	RI	*P /83 (-)	(H 5634) The Rhode Island legislature reports introduction of a bill to allow a \$300 tax credit for the care of elderly, disabled, mentally ill, or mentally retarded individuals at home.
*	SC	*A 11/82 (+)	South Carolina rescinded its nursing home bed freeze.
	SD	*X 1/82 (-)	(SB 38) The South Dakota legislature reported that a bill was introduced to impose a two-year CON moratorium on nursing home bed expansion. This proposal was dropped.

- \* TX \*A 5/83 ( ) (SCR 20) The Texas legislature enacted a law which requested that the Department of Human Resources apply for an 1115 waiver to permit reimbursement for education and training programs for the prevention of diabetes at four pilot program centers.
- \* TX \*A /83 ( ) The Texas Medicaid agency did a study on the cost impacts which would result from various program reductions. This was done so that, in the event that budget deficits ever require program cuts, preliminary research will have been completed and decisions can be made more quickly.
- UT \*A 1/82 (+) (HJR 37) The Utah legislature passed a Joint Resolution to study Medicaid optional services.
- \* VT \*A /83 ( ) The Vermont legislature established a committee (the "Data Council") to review and publicize hospital budgets and to submit recommendations for appropriate changes.
- VT \*A 7/82 (-) (H 721) The Vermont legislature passed a law which establishes a fund to receive donations, appropriations and federal matching funds to be used to promote community living programs for the elderly and handicapped.
- VA \*A /82 (+) (HB 654, HB 91) The Virginia legislature enacted laws which provide criteria for excluding adult homes and nursing homes from CON requirements.
- VA \*A /82 (-) (HB 879) The Virginia legislature approved a bill to extend a CON moratorium on nursing homes until June 30, 1983.
- WA \*A /82 (+) The State of Washington completed a demonstration to provide hospice services to terminally ill Medicare beneficiaries and Medicaid recipients.
- \* WV \*A 7/83 (-) (SB 320) The West Virginia legislature enacted a law which established, as of July 1, 1983, the West Virginia Health Care Cost Review Authority, a three-member board that will review, investigate and approve hospital rates and budgets (for all payors) and will review CON applications. The Board must allow sufficient funds to meet the federal requirement that they will be "reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated hospitals..."

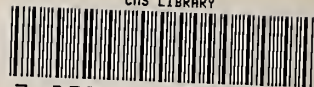


and must make allowances for hospitals caring for a disproportionately large number of needy patients. Medicaid recipients must also be assured adequate access to inpatient hospital care.

- \* WI \*A 5/83 (-) Wisconsin is continuing its moratorium on issuance of Certificates of Need (CON) for acute care hospital beds.
- \* WI \*C /83 (-) Wisconsin is considering the establishment of a statewide limit on capital expenditures for acute care hospital beds.
- \* WI \*A /83 (-) (SB 83) The Wisconsin legislature passed legislation that extends the scope of the Gatekeeper Prudent Buyer Plan for reimbursement of mental health, alcohol and drug abuse services. Participating counties receive an allocation of state Medicaid funds equal to the state share of expenditures for current utilization of these services. The participating counties would then be at risk for the nonfederal share of expenditures beyond current utilization levels. Funds not spent for such services could be used for other community-based services.



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